



**Department of Social and Health Services
Health and Recovery Services
Administration (HRSA)**



**Tribal Health Program
Billing Instructions for
Tribal Health Programs and Indian Health
Services Providers**

ProviderOne Readiness Edition

About this Publication

This publication supersedes all previous Department/HRSA *Tribal Health Program Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

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How Can I Get Department/HRSA Provider Documents?

To download and print the Department /HRSA provider numbered memos and billing instructions, go to the Department /HRSA website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memorandum* link).

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Table of Contents

Section A: Introduction

Important Contacts.....	A.1
Important Numbers	A.2
List of Department /HRSA Billing Instructions	A.3
Definitions & Abbreviations.....	A.4

Section B: Tribal Health Program

The Department, HRSA, and Federally Recognized Tribes.....	B.1
Billing Instructions for the Tribal Health Program.....	B.2
Tribal Health Care Facilities.....	B.2
Types of Tribal Health Care Facilities.....	B.2
Health Care Facilities Licensed, Accredited, or Deemed Medicaid Eligible	B.3
Health Care Facilities Payment Structure.....	B.3
IHS-Recognized Providers.....	B.3
National Provider Identification Number	B.4
How to Bill.....	B.5
Department Managed Care Enrollment/Disenrollment Options.....	B.7
Department Managed Care Programs	B.8
Prepaid Inpatient Health Plan Managed Care.....	B.9

Section C: Client Eligibility

Who Is Eligible?	C.1
------------------------	-----

Section D: Payment

Medical Coverage Groups Eligible for the Encounter Rate	D.1
Benefit Service Packages <i>Not</i> Eligible for the Encounter Rate	D.2
Are Clients Enrolled in an MCO Eligible for Payable Services Provided By an IHS or Tribal 638 Facility?.....	D.3

Section E: Encounter vs. Fee-for-Service

How Do I Determine If a Service Qualifies as an Encounter?	E.1
Types of Encounters	E.1
Who Is Eligible To Perform Encounter Services?.....	E.3
Types of Services That Do NOT Qualify as Encounters.....	E.4
Services Not Covered by the Department.....	E.5

Table of Contents (continued)

Section F: Medical Services

Medical Encounters F.1
 How Do I Bill For a Medical Service Encounter? F.2
 Medical Fee-for-Service F.3
 Diabetes Education Program..... F.3
 Durable Medical Equipment (DME) F.4
 The Department Approved Family Planning Provider Programs..... F.5
 Maternity Support Services (MSS)/Infant Case Management (ICM) F.6
 Non-Durable Medical Supplies and Equipment (MSE) F.7
 Pharmacy Services F.8
 What Is the Goal of the Prescription Drug Program? F.8

Section G: Dental Services

Dental Encounters G.1
 How Do I Bill for a Dental Services Encounter?..... G.2
 Dental Fee-for-Service..... G.3
 Orthodontics..... G.5
 Prior Authorization (PA)..... G.6

Section H: Mental Health Services

Mental Health Encounters..... H.1
 Who is Eligible to Bill the Mental Health Encounter Rate?..... H.2
 How Do I Bill for a Mental Health Encounter? H.2
 Psychiatric Service Encounters (Specialized Medical Encounter) H.3
 How Do I Bill for a Psychiatric Services Encounter H.3

Section I: Chemical Dependency and Treatment Services

Chemical Dependency Encounters I.1
 Who Is Eligible to Bill for a Chemical Dependency Encounter I.1
 Payment for a Chemical Dependency Encounter I.1
 What Is the Process for an Inter-Governmental Transfer (IGT)..... I.2
 How Do I Bill for a Chemical Dependency Encounter I.3

Section J: Coverage Table

Division of Behavioral Health and Recovery Alcohol and Drug
 Treatment Outpatient Services..... J.1
 Coverage/Limitations Table..... J.3

Table of Contents (continued)

Section K: Billing
 What Are the General Billing Requirements?K.1
 What Are the Record Keeping Requirements Specific to
 Chemical Dependency Treatment Providers?.....K.1

Section L: State Children’s Health Insurance Program
 Chemical Dependency L.1
 Medical and Dental L.2
 Mental Health..... L.2

Section M: Administrative Contract Programs
 Medicaid Administrative Match (MAM)..... M.1
 Primary Care Case Management (PCCM)..... M.1

Section N: Completing the CMS-1500 Claim Form
 General Information.....N.1

Appendix
 Eligibility Verification of Managed Care Plans and Plan Contact Information1
 Medicaid State Plan: Department/HRSA Tribal Mental Health Benefit Tribal
 Provider Staff Eligible to Bill the Encounter Rate.....3
 Rehabilitative Services (Tribal MH Services) Services Description Table5
 Tribal Billing Codes.....13
 Encounter Codes13
 Fee-for-Service Codes14
 Canadian First Nation Medicaid Eligibility15
 Medicaid15
 Crossing the U.S. Border to Live and/or Work15
 IHS Manual16
 Services Card17
 How Do I Check a Client’s Eligibility with the New Services Card?18
 Medical Identification Description Table19

Important Contacts

Note: This section contains important contact information relevant to the Tribal Health Program. For more contact information, see the Department /HRSA *Resources Available* web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See The Department/HRSA <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or the Department approved managed care organizations	
Electronic or paper billing	
Finding the Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than the Department managed care	
Mental Health Services	Mental Health Division Tribal Liaison 1-360-902-0812 http://www1.dshs.wa.gov/mentalhealth/Tribal_Internet_Map_20060516.shtml
Tribal Health-medical or dental services	Native Health Program Manager 1-360-725-1649 http://hrsa.dshs.wa.gov/tribal/
Chemical dependency services	Title XIX Coordinator 1-360-725-3750 http://www.dshs.wa.gov/dasa/
Viewing the following Department client publications: <ul style="list-style-type: none"> • Guide for People getting services from Washington State Medical Assistance (#22-530); and • Healthy Options Guide (#22-542). 	Visit the Department's Client Publications website at: http://www.dshs.wa.gov/geninfo/pubs3.html

Important Numbers

Casualty questions1-800-562-3022 ext 15462

Coordination of Benefits Section.....1-800-562-3022 ext 16134

Disability Insurance1-800-562-6074

DME*/Prosthetics & Orthotics Authorization (**Providers Only**)1-800-532-3022 ext 15466

Electronic Billing Questions (call this number and press option “2”).....1-800-562-3022

Fraud Hotline1-800-562-6906

Home Health/Plan of Treatment1-360-725-1582

Medical Assistance Customer Service Center (MACSC)1-800-562-3022

Client: Access to Medical Care, Broker Transportation,
Client Complaints or Assistance, Healthy Options Enrollment,
Disenrollment, Exemptions, and Interpreter questions

Providers: Authorization Status, Claims, Client Eligibility, Warrants

Provider Enrollment.....1-800-562-3022 ext 16137

Medical Eligibility Determination Services (MEDS).....1-800-562-3022 ext 16136

Medicare Unit Fax Line1-360-664-2186

Pharmacy Authorization (**Providers Only**).....1-800-562-3022 ext 15483

TAKE CHARGE questions1-800-562-3022 ext 15481

Telecommunications Device for the Deaf (TDD)1-800-848-5429

*Durable Medical Equipment

List of Department/HRSA Billing Instructions

Access to Baby & Child Dentistry (ABCD)
Acute Physical Medicine & Rehabilitation
(PM&R)
Ambulance and Involuntary Treatment Act
(ITA) Transportation
Ambulatory Surgery Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program for Clients Age 21 and
Older
Dental Program for clients Through Age 20
Diabetes Education Program
Early, Periodic Screening, Diagnosis, and
Treatment (EPSDT)
Enteral Nutrition Program
Family Planning Provider
Federally-Qualified Health Centers (FQHC)
Healthy Options/Basic Health Plus/CHIP
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice Services
Hospital Inpatient
Hospital-Based Inpatient Detoxification
Hospital Outpatient
Kidney Center Services
Long Term Acute Care (LTAC) Program
Maternity Support Services/Infant Case
Management
Medical Nutrition Therapy
Mental Health Services for Children
Neurodevelopmental Centers
Nondurable Medical Supplies and
Equipment (MSE)
Nursing Facilities

Occupational Therapy Program
Orthodontic Services
Oxygen and Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births and Births in Birthing
Centers
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing for Children
Prosthetic and Orthotic Devices
ProviderOne Billing and Resource Guide
Psychologist
Rural Health Clinic
School-Based Healthcare Services for
Special Education Students
Speech/Audiology Program
Tribal Health Program
Vision Care Services
Wheelchairs, Durable Medical Equipment &
Supplies (DME)

**To obtain DSHS's/HRSA's Billing
Instructions:**
Visit the DSHS/HRSA web site:
<http://hrsa.dshs.wa.gov/> and click **Billing
Instructions/Numbered Memoranda.**

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

“638” Compact - Compact or (Annual Funding Agreement) to carry out Self-Governance as authorized by Title II, P.L. 103-413, III, P.L. 100-472, which built upon the Self-Governance Demonstration Project and transfers control to tribal governments, upon tribal request, over funding and decision making of Federal programs, activities, functions, and services as an effective way to implement the federal policy of government- to-government relations with Indian Tribes. Allows tribes to:

- Redesign programs, activities, functions, and services of the Bureau of Indian Affairs (BIA);
- Reallocate funds for such programs, activities, functions, or services according to its Tribal priorities;
- Provide such programs, activities, functions, and services, as determined by its Tribal priorities;
- Enhance the effectiveness and long term financial stability of its Tribal government;

- Plan, conduct, consolidate, and administer programs, activities, functions and services, or portions thereof, administered by the Department of the Interior, other than through the Bureau of Indian Affairs (BIA) as provided in the annual funding agreement applicable to such non BIA programs, activities, functions and services; and
- Reduce the Federal-Indian service bureaucracy.

Compact is and shall be enforceable at law and in equity to the same extent and pursuant to the same remedies as provided for in Public Law 93-638 contracts in Title III, Section 303(d) of P.L. 100-472.

“638” Contract – A contract between tribes and the Indian Health Service (IHS) that states tribes will assume responsibility for providing social and health care services to American Indian/Alaska Natives (AI/AN). Authorized by Public Law 93-638, the Indian Self Determination Act.

ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) – A state-funded program to provide chemical dependency treatment and support services for indigent alcoholics and addicts seeking alcohol or drug rehabilitation in Washington State.

Alcohol Abuse - Use of alcohol in amounts dangerous to individual health or safety.

Alcoholism - A disease characterized by:

- A dependence on alcoholic beverages or the consumption of alcoholic beverages;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance;
- Physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Alcoholism and/or Alcohol Abuse Treatment (Outpatient) - Medical and rehabilitative social services provided to an eligible patient designed to mitigate or reverse the untoward effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by a combination of alcohol education sessions, individual therapy, group therapy, and related activities provided to detoxified alcoholics and their families.

American Society of Addiction Medicine (ASAM) – An international organization of physicians dedicated to improving the treatment of persons with substance use disorders.

American Indian/Alaskan Native (AI/AN)
- Persons having origins in any of the original peoples of North America.

Approved Chemical Dependency Treatment Facility -

A treatment facility, either public or private, for profit or nonprofit, approved by DSHS pursuant to WAC 388-805 and RCW 70.96A.

Assessment - The set of activities conducted on behalf of a new patient, for the purpose of determining eligibility, evaluating treatment needs, and making necessary referrals and completing forms. The assessment includes all practices listed in applicable sections of Chapter 388-805 WAC or its successor.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Bureau of Indian Affairs (BIA) – Federal Agency under the Department of the Interior responsible for the administration and management of land held in trust by the United States for American Indians, Indian tribes, and Alaska Natives. Developing forestlands, leasing assets on these lands, directing agricultural programs, protecting water and land rights, developing and maintaining infrastructure, providing for health and human services, and economic development are all part of this responsibility taken in cooperation with the American Indians and Alaska Natives.

Canadian First Nation Medicaid

Eligibility – People born in Canada, having at least 50% Aboriginal blood, and who are unable to work or who have lost their job, may be entitled to one or more of the following government benefits: Medicaid, Supplemental Security Income (SSI), Food Stamps, Disability, Social Security, and Medicare.

<http://www.lawhelp.org/documents/4312719204EN.pdf?stateabbrev=WA/>. Refer to the Appendix for further information.

Centers for Medicare and Medicaid

Services (CMS) - The agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for Medicare and Medicaid programs. [[WAC 388-531-0050](http://www.wa.gov/388-531-0050)]

Certified Chemical Dependency Treatment Facility - A treatment facility, either public or private, for profit or nonprofit, approved by the Department pursuant to WAC 388-805 and RCW 70.96A.

Chemical Dependency Case Management

– Services provided by a Chemical Dependency Professional (CDP) or CDP Trainee to patients assessed as needing treatment and admitted into treatment. Services are provided to assist patients in gaining access to needed medical, social, educational, and other services. Services include case planning, case consultation and referral, and other support services for the purpose of engaging and retaining or maintaining patients in treatment.

Chemical Dependency - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

Chemical Dependency Professional Trainee (CDPT) – A person certified as a chemical dependency professional trainee by the Washington State Department of Health under Chapter 18-205 RCW.

Children’s Administration (CA) Initial Screen

– The initial expanded assessment process for CA-referred patients in which the chemical dependency agency begins, but does not complete the expanded assessment due to the patient failing to return to complete expanded assessment:

- Begins the assessment process;
- Completes the initial-short assessment and the urinalysis.

Child Psychiatrist - A person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

Clinical Family Member (for mental health services only) - A person who maintains a familial relationship with a tribal member, including:

- A spouse or partner of an eligible AI/AN.
- An individual who has not attained 19 years of age, or is an incapacitated adult; *and* is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible AI/AN.
- A child in common, a foster or custodial child, or an adopted child placed within a family unit in which any member is an eligible AI/AN.
- A non AI/AN woman pregnant with an eligible AI/AN's child. If unmarried, the woman is eligible if the eligible AI/AN male attests in writing that he is the father of the unborn child, or AI/AN paternity is determined by order of a court of competent jurisdiction.
- A non AI/AN adult who has guardianship, custodial responsibility, or is acting *in loco parentis* (to assume the duties and responsibilities of a parent or acting as temporary guardian) for an eligible AI/AN minor.

Clinical Social Worker - As defined by [Title 42 USC, 1395x\(hh\), Sec. 1861\(hh\)\(1\)](#) means an individual who:

- Possesses a master or doctor's degree in social work;
- After obtaining such a degree, has performed at least two years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed, or
- In the case of an individual in a state which does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary of Health and Human Services), and II. Meets such other criteria as the Secretary of Health and Human Services establishes.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Continuing Care Plan - Documentation of care beyond the current level of care based on the patient's needs, access, choice and services.

Counselor – An individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

Coordination of Benefits – The mechanism developed to prevent duplication of payment when one or more than one insurance plan or payer covers a person.

Courtesy Dosing – Temporary dosing from another approved Opiate Substitution Treatment facility provided to a patient when they are away from their home clinic.

Criminal Justice Treatment Account (CJTA) – A fund authorized by the state Legislature to provide community-based substance abuse treatment alternatives for offenders with an addiction or substance abuse problem against whom charges are filed by a prosecuting attorney in Washington State.

Current Procedural Terminology- (CPT) - Descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties. Developed by the American Medical Association (AMA).

Detoxification – The care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

- *Acute Detoxification Services* – A method of withdrawing a patient from alcohol or other drugs where nursing services and medications are routinely administered under physician supervision to facilitate the patient’s withdrawal. Acute Detoxification services include all services in Chapter 246-337 WAC and Chapter 388-805 WAC or its successors.

- *Sub-Acute Detoxification Services* – A method of withdrawing a patient from alcohol or other drugs utilizing primarily social interaction between patients and staff within a supportive environment designed to facilitate safety for patients during recovery from the effects of withdrawal from alcohol or other drugs. Withdrawal medications are ordered by a physician and self-administered by the patients, not staff. Sub-acute detoxification services include all services in Chapter 246-337 WAC and Chapter 388-805 WAC or their successors.

Division of Behavioral Health and Recovery (DBHR) - The Division of Behavioral Health and Recovery (DBHR) provides support for Mental Health, Chemical Dependency, and Problem Gambling Services. The public mental health programs promote recovery and resiliency and reduces the stigma associated with mental illness. The substance abuse prevention and chemical dependency treatment programs promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. The problem gambling program mitigates the effects of problem gambling on the family and helps families remain economically self-sufficient without requiring assistance from other state programs. DBHR also brings operational elements like medical assistance, chemical dependency and mental health into closer working relationships that serve clients more effectively and efficiently than before.

Drug Abuse - The use of a drug in amounts dangerous to a person's health or safety.

Drug Addiction - A disease characterized by:

- A dependency on psychoactive chemicals;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Drug Addiction (for Adults) and/or Drug Abuse (for Pregnant or Youth)Treatment

- Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities provided to detoxified addicts and their families.

Emergency Care - Service provided for a person that, if not received, would likely result in the need for crisis intervention or for hospital evaluation due to concerns of potential danger to self, or to others, or grave disability.

Encounter - An encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of medically necessary, Medicaid-defined services from an Indian Health Services (IHS) or Tribal 638 facilities within a 24-hour period beginning and ending at midnight. An outpatient contact between a Medicaid beneficiary and more than one health care professional in a single IHS or Tribal 638 facility, within the same 24-hour period, and the services provided are a result of the same diagnosis, constitutes a single encounter.

Expanded Chemical Dependency

Assessment - Comprehensive assessments provided for either of the following:

1. Adults receiving Supplemental Security Income (SSI) or SSI-related medical assistance (aged, blind, or disabled adults) whose assessment is conducted in an off-site setting, such as a nursing home or the patient's home. The off-site setting must meet the criteria in WAC 388-805-640.
2. Adults who are referred by the Children's Administration (CA) staff. These comprehensive assessments must include all of the following:
 - a. A diagnosis of chemical dependency;
 - b. The recommended level or modality of chemical dependency treatment based on ASAM that includes the recommended duration of chemical dependency treatment;
 - c. A list of the assessment instruments/tools used in the assessment process;

- d. Psychosocial history, including past drug/alcohol use, financial problems, education, and legal issues;
- e. Information from collateral contacts that include friends, relatives, immediate and extended family members, and professional service providers who have had prior involvement with the patient;
- f. Results of an initial urinalysis; and
- g. Prognosis for recovery.

Family Planning Only program - The program providing an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the 60-day post-pregnancy coverage for women who received medical assistance benefits during the pregnancy. This program's coverage is strictly limited to family planning services.
[WAC 388-532-505]

Federally Qualified Health Center (FQHC) - A facility that is:

- Receiving grants under section 330 of the Public Health Services Act; or
- Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service Act, as determined by the Secretary to meet the requirements for receiving such a grant, or
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

Federally Recognized Tribe - Tribal entities acknowledged by the US Government and eligible for funding and services from BIA by virtue of their status as Indian tribes. Tribes are acknowledged to have the immunities and privileges available to other federally acknowledged Indian tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations, and obligations of such tribes.
http://factfinder.census.gov/home/aian/indian_entities_11-25.pdf

Group Therapy - Planned therapeutic or counseling activity conducted by one or more certified CDPs or CDPTs to a group of three or more unrelated individuals and lasting at least 45 minutes.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Health Care Provider - Written recommendations from the following licensed health care practitioners are presumed to be within their scope of practice under state law:

- Certified Chemical Dependency Professional (CDP);
- Physicians, Osteopaths;
- Naturopaths;
- Physician's Assistants;
- Osteopathic Physician's Assistants;
- Certified Nurse Practitioner; and
- Registered Nurses.

Health Care Financing Administration (HCFA) – See **Centers for Medicare & Medicaid Services**.

Health Maintenance Organization (HMO)

– An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the Department on a prepaid capitation risk basis.

HIPAA- [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) – An Act that:

- Protects health insurance coverage for workers and their families when they change or lose their jobs;
- Establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers; and
- Addresses the security and privacy of health data.

Indian Health Service (IHS) - A federal agency under the Department of Health and Human Services (the Department) and contracted tribal health programs entrusted with the responsibility to assist eligible AI/AN with health care services.

IHS Beneficiary –AI/AN who provide proof of being a member in or a descendent of an Indian tribe recognized by the U.S. government are eligible for services funded by the IHS. Refer to the Appendix for information on Canadian eligibility.

IHS/OMB Encounter – A face-to-face contact between a health care professional and a Medicaid beneficiary in order to provide Title XIX defined services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight, as documented in the patient’s record.

Indian Health Service/Tribal (I/T) - A health facility run by the IHS as a direct service unit, or a Tribal 638 facility run by the tribe.

Individual Therapy - A planned therapeutic or counseling activity provided to an eligible patient by a certified CDP or CPDT. Individual therapy includes treatment provided to a family group consisting of a primary patient and one or more significant others, or treatment provided to a couple who are partnered. Individual therapy may be provided to a family group without the primary patient present.

Intake Processing- The set of activities conducted on behalf of a new patient. Intake processing includes all practices listed in applicable sections of Chapter 388-805 WAC or its successor.

Managed Care Organization (MCO) - An MCO is an entity that finances and delivers health care using a specific provider network and specific services and products.

Maternity Support Services (MSS) - Preventive health services for pregnant/postpartum women, including assessment, education, intervention, and counseling provided by an interdisciplinary team of community health nurses, nutritionists and psychosocial workers; childbirth education, and authorization of childcare. Community health worker visits may also be provided.

Maximum Allowable - The maximum dollar amount THE DEPARTMENT will pay a provider for a specific service, supply, or piece of equipment.]

Medical ID Card – See *Services Card*.

Medically Necessary – See [WAC 388-500-0005](#)

Memorandum of Agreement (MOA) – Specifically, the December 19, 1996 memorandum that established the roles and responsibilities of the federal Health Care Financing Administration (HCFA) (now CMS) and the IHS regarding AI/AN individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).

Mental Health Professional –

1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters [71.05](#) and [71.34](#) RCW;
2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
3. A person who meets the waiver criteria of RCW [71.24.260](#), which was granted prior to 1986;

4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with [WAC 388-865-0265](#).

Mid-Level Practitioner – Advanced Registered Nurse Practitioner (ARNP), Certified Nurse Midwife, Woman's Health Care Nurse Practitioner, Physician's Assistant (PA), Psychiatric ARNP, Clinical Social Worker, or Mental Health Mid-Level Practitioner.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Opiate Substitution Treatment (OST) - Services provided to patients in accordance with Chapter 388-805 WAC or its successor. Bill for OST services are all-inclusive and must include, as a minimum, the following services: assessment; physical examination, upon admission; urinalysis testing one time per month; initial treatment plan and treatment plan review one time per month; vocational rehabilitation services as needed (may be by referral); dose preparation and dose dispensing; detoxification if and when needed; patient case management; individual and/or group counseling one time per month; one session of family planning; HIV screening, counseling, and testing referral; and psychological screening.

Patient - A person that has been admitted and receiving healthcare services from a DSHS-certified agency or a qualified health provider.

Pregnant and Postpartum Women (PPW) Assessment – Assessment provided to an eligible woman who is pregnant or postpartum. The postpartum period covers the 60 days after delivery and any remainder of the month in which the 60th day falls.

Prepaid Inpatient Health Plan (PIHP) –An entity that:

- Provides medical or mental health services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; and
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system

ProviderOne Client ID- A system assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.

For example: 123456789WA.

Psychiatric Nurse - A registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

Psychiatrist - A person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

Psychologist - A person who has been licensed as a psychologist under [Chapter 18.83 RCW](#).

Rehabilitation Case Management – A range of activities by the outpatient community mental health agency’s liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include:

- Assessment for discharge or admission to mental health care;
- Integrated mental health treatment planning;
- Resource identification and linkage to mental health rehabilitative services; and
- Collaborative development of individualized services that promote continuity of mental health care.

These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned readmission, and to increase the community tenure for the individual.

Services are provided by or under the supervision of a mental health professional.

Revised Code of Washington (RCW) -
Washington State laws.

Services Card – A plastic “swipe” card that the Department issues to each client on a “one- time basis.” Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client’s name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Social Service Payment System (SSPS) – The payment system THE DEPARTMENT uses to pay for a variety of services that facilitate employment, increase independence, and protect children, the fragile elderly, and disabled children and adults.

Social Worker - A person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

Staff Supervision – The monitoring of the administrative, clinical, or clerical work performance of staff, students, interns, volunteers, or contracted employees by persons with the authority to direct employment activities and require change.

TAKE CHARGE – The Department’s demonstration and research program, approved by the federal government under a Medicaid program waiver that provides family planning services.
[WAC 388-532-710]

TAKE CHARGE Provider - A provider who is approved by the Department to participate in TAKE CHARGE by:

- Being an approved the Department family planning provider; and
- Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally-approved Medicaid waiver for the TAKE CHARGE program.
[WAC 388-532-710]

Temporary Assistance For Needy Families (TANF) - The federal welfare program established in 1996 that combined the Aid to Families with Dependent Children (AFDC) (cash aid) and the JOBS Opportunities and Basic Skills (welfare-to work) programs into one program funded by one federal block grant.

Temporary Assistance For Needy Families TANF Client - Clients eligible for TANF who are receiving assessment and treatment services.

Taxonomy Code - A unique, 10-digit, alphanumeric code that allows a provider to identify their specialty category. Providers applying for their NPI will be required to submit their taxonomy information. Providers may have one or more than one taxonomy associated to them. Taxonomy Codes can be found at <http://www.wpc-edi.com/codes/Codes.asp>.

Title XXI - State Children's Health Insurance Program- The portion of the federal Social Security Act that authorizes grants to states to initiate and expand the provision of child health assistance to uninsured, low-income children program Title XXI is also called CHIP.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Tribal 638 Facility – A facility operated by a tribe or a tribal organization, and funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 3-638).

Tribal Chemical Dependency Treatment Services Program– A qualified tribal chemical dependency treatment program which contracts with the Department of Social and Health Services (the Department) under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration (now CMS) and Indian Health Services.

Tribal Mental Health Services – A tribal mental health program which enters into an agreement with the Department under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration (now CMS) and Indian Health Services.

Tuberculosis (TB) Testing - Administration and reading of the Intra-dermal Skin Test, to screen for tuberculosis, by: licensed practitioners within the scope of their practice as defined by state law or by the Department of Health (DOH) WACs; or as provided by a tuberculosis community health worker approved by the DOH.

Urinalysis – Analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the Department of Health.

Usual and Customary Charge - The fee that the provider typically charges the general public for the product or service.

Washington Medicaid State Plan – The official federally recognized statement describing the nature and scope of Washington State's Medicaid program. The State Plan addresses program administration, Medicaid eligibility, service coverage, and provider reimbursement.

Washington Medicaid Integration Partnership (WMIP) – Voluntary managed care plan for Aged, Blind and Disabled clients in Snohomish County which includes coverage of some chemical and dependency services.

Tribal Health Program

The Department of Social and Health Services, Health and Recovery Services Administration, and Federally Recognized Tribes

The State of Washington recognizes the intent of Congress to provide Medicaid funds to Indian Health Service and Tribal governments for the delivery of Medicaid services to eligible members of Federally Recognized Tribes. The Department of Social and Health Services (the Department) Health and Recovery Services Administration (HRSA) supports a "government to government" relationship with the Tribes and the State of Washington in order to deliver these services.

The Department collaborates with Federally Recognized Tribes to use all possible Medicaid and State Health services to address the health needs and raise the health status of American Indians/Alaska Natives (AI/AN) to the highest possible level.

In accordance with federal policy, an Indian tribe, tribal organization, or Alaska Native health organization may bill Medicaid if the:

- Facility is eligible to participate in the Medicare or Medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);
- Program and facility is on the Indian Health Services (IHS) facility list;
- Organization or tribe contracts or compacts for the operation of an IHS facility; and
- Facility meets the requirements that apply to programs operated directly by IHS.

A tribe or tribal organization can bill for Medicaid State Plan services as long as the tribe or tribal organization meets all of the conditions and requirements which are applicable to such facilities under Section 1911 of the Social Security Act.

Tribal programs that are not identified on the IHS facility list and do not compact or contract for services with the IHS, may become a qualified provider under the same qualifications as a provider identified in the Medicaid State Plan.

Billing Instructions for Tribal Health Programs

These billing instructions explain how the Department pays for services provided by tribal health care facilities to clients receiving Medicaid or other types of public assistance.

Tribal Health Care Facilities

Under the Health Care Financing Administration/Indian Health Service (HCFA/IHS) Memorandum of Agreement (MOA) dated December 16, 1996, tribal health care facilities may choose to be designated as a certain type of provider or facility. The designation determines how the Department pays for Medicaid services provided by a facility. This section describes the types of facility that tribes may choose, and the associated payment structure. For a facility to be eligible to receive the IHS/OMB encounter rate the program and facility need to be identified on the IHS facility list. Facilities and practitioners must meet Medicaid State Plan requirements for accreditation and licensure.

Types of Tribal Health Care Facilities

Tribal facilities may choose to be designated as:

- **IHS and Tribal 638 Facilities: If eligible** a health care facility may be designated as one of the following two types of IHS facilities, which are paid the federal IHS encounter rate:
 - ✓ An **IHS facility** which is established, operated, and funded by the IHS; or
 - ✓ A **Tribal 638 facility** which is tribally owned and operated and funded by Title I or Title V of the Indian Self Determination and Education Assistance Act (Public Law 93-638) and identified on the IHS facility list.
- **Tribal Facilities:** Health care facilities operated by federally recognized tribes or tribal organizations which are not designated as a Tribal 638 or IHS facilities. (This includes all health facilities not listed on the IHS facility list as a Tribal 638 or IHS facility.) These facilities are paid standard Medicaid Fee-for-Service (FFS) rates.
- **Federally Qualified Health Centers (FQHCs):** Tribal facilities may choose to be designated as FQHCs. For more information regarding FQHCs see the Department /HRSA *Federally-Qualified Healthcare Centers Billing Instructions* available online at: http://hrsa.dshs.wa.gov/download/BillingInstructions/FQHC_BI.pdf.

Health Care Facilities Licensed, Accredited, or Deemed Medicaid Eligible

All IHS/638 facilities must meet *all* conditions and requirements applicable under the Medicaid statute.

All facilities that participate must:

- Must meet state requirements for Medicaid;
- Meet state certification standards for facility /program type; or
- Become accredited by a national accreditation body such as the following:
 - ✓ Joint Commission Accreditation for Healthcare Organizations (JCAHO);
 - ✓ Commission on Accreditation of Rehabilitation Facilities (CARF); or
 - ✓ Council on Accreditation (COA.)

The IHS/638 facility:

- Must meet state requirements for Medicaid;
- Does not need to be licensed, but must meet all state standards for licensure; and
- Must be approved by the Department.

Health Care Facilities Payment Structure

The Department pays tribal health care facilities according to their self-designated provider or facility type.

IHS-Recognized Providers

- **IHS and Tribal 638 Facilities:** Are paid for most services through an all-inclusive encounter rate. The encounter rate is an outpatient, per-visit rate which includes all on-site laboratory and x-ray services, as well as all medical supplies incidental to the services provided to the client during the visit. The Federal Office of Management and Budget publishes the encounter rate in the Federal Register each fall; the rate is retroactive to the first of the year. The Department automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate. A numbered memorandum is published on the Department/HRSA website: <http://hrsa.dshs.wa.gov/download/Numberedmemos.html> that announces the implementation date, along with a postcard that is sent to IHS and tribal facilities.

- **Tribal Facilities:** Health care facilities NOT designated as Tribal 638 facilities are paid the state-determined fee-for-service (FFS) payment rate for services provided. Refer to the appropriate program-specific billing instructions for information about provider and client eligibility, covered services, and payment rates.
- **Federally Qualified Health Centers (FQHCs):** Tribal facilities may choose to be designated as FQHCs. For more information regarding FQHCs see the Department /HRSA *Federally-Qualified Healthcare Centers Billing Instructions* available online at: http://hrsa.dshs.wa.gov/download/BillingInstructions/FQHC_BI.pdf.

National Provider Identification (NPI) number

Each eligible IHS tribal facility may request an NPI number based on the billing category of service. Once approved the facility must use the appropriate NPI number and taxonomy code to receive payment from HRSA. The Department accepts an NPI number for:

- Medical services;
- Dental services;
- Mental health services;
- Chemical dependency treatment services; and
- Various Medicaid and Administrative FFS programs (e.g., pharmacy services).

Providers need a core provider agreement (CPA) for each NPI number registered. If a facility has different clinic sites, an NPI NUMBER may be assigned for each site. A facility may bill for services provided at satellite locations for services provided by facility/clinic personnel. Satellite locations must be identified under the accreditation or certification of the primary health program.

For tribal programs registering as a non IHS/638 facility standard Washington Medicaid enrollment applies.

For an IHS/638 facility, when adding a new clinic or service, indicate on the upper right hand corner of the CPA application that you are a tribal facility. HRSA's Provider Enrollment Unit will contact the appropriate program manager for processing of the application. In some instances an additional contract will be needed to process the application. Submit the application to:

Attn: Tribal Enrollment Coordinator
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Chemical dependency treatment services must be provided at facilities that meet the appropriate certification criteria. A separate NPI can be established for each facility where treatment services are provided. For more information regarding Substance Abuse service contracts please contact the DBHR Title XIX Coordinator (refer to the Important Contacts Section).

Note: In order to be paid for chemical dependency treatment services to non-Department clients, a tribal facility must contact the chemical dependency services program manager for a contract.

How to Bill

Washington Medicaid uses federally mandated Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT[®]) codes, and Current Dental Terminology (CDT[®]) codes. When billing, you *must* submit claims on the appropriate form or on an 837 Health Insurance Portability and Accountability Act- (HIPAA) compliant transaction.

Encounters:

When billing for an encounter, you must use the following when billing for the services in the table below:

- HCPCS procedure code **T1015** (the encounter code for all Indian Health Clinic services);
- The appropriate modifier*;
- The appropriate ICD-9-CM diagnosis code*;
- The appropriate billing and rendering provider taxonomy codes.

Note: The Department requires valid and complete ICD-9-CM diagnosis codes. When billing HRSA, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

Some services may require Prior Authorization (PA) from the Department. This is determined by referring to the individual billing instructions (i.e. Dentures, and Exception to Rules (ETR)).

* Modifiers are used to identify AI/AN clients and non-native clients.

Tribal Health Program

When billing Fee-for-Service (FFS) for the services in the table below, use the following

- The appropriate CPT, HCPCS, or CDT procedure code;
- The appropriate modifier*;
- The appropriate ICD-9-CM diagnosis code*;
- The appropriate billing and rendering provider taxonomy codes.

Type of Service	Type of Form
Chemical dependency encounters Dental encounters Medical encounter services & FFS Mental health encounters	837P HIPAA-compliant transaction or CMS-1500 Claim Form
Dental FFS services	837 HIPAA-compliant transaction or ADA (version 2006) Dental Form
Pharmacy services	Pharmacy Statement Claim Form 525-106 or Point-of-Sale (POS) system

The Department requires separate ICD-9-CM diagnosis codes for psychiatric and dental encounters (see table below).

Type of Service	ICD-9-CM Diagnosis Code Required
Dental	520-525.9 or V72.2
Psychiatric	290-319

*For a list of appropriate modifiers and diagnosis codes, refer to the Appendix.

The Department requires distinct billing taxonomy on all tribal encounter claims (see table below).

Program	Facility (billing) Taxonomy
Dental	122300000X
Medical	208D00000X
Psychiatric (specialized medical encounter)	2084P0800X
Mental Health	2083P0901X
Substance Abuse	261QR0405X

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Department Managed Care Enrollment/Disenrollment Options

If a client is an AI/AN who meets the provisions of [25 U.S.C. 1603\(c\)\(d\)](#) for federally recognized tribal members and their descendants, the client may choose one of the following for their medical or mental health care per [WAC 388-538-130](#):

- Enrollment with a managed care organization available in their area;
- For Healthy Options clients, enrollment with an IHS or tribal primary care case management (PCCM) provider, if available in their area; or
- The Department's fee-for-service system

If the client is enrolled in a MCO and chooses to enroll with a tribal PCCM, the client must be disenrolled from the MCO before he or she is seen at a tribal health clinic. To disenroll the client may call the HRSA Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022 (toll free) or complete a Managed Care Enrollment/Disenrollment Request form, DSHS 13-778, at:

<http://hrsa.dshs.wa.gov/msa/forms/index.html>

Send or fax the completed form to:

HRSA-Division of Eligibility and Service Delivery
PO Box 45562
Olympia WA 98504-5562
FAX: 1-360-725-2144

Note: Expedited disenrollment from a MCO is available by calling toll free 1-800-562-3022.

Department Managed Care Programs

AI/AN clients must receive their medical care through the state’s contracted managed care organizations (MCOs) when enrolled in any managed care program in the following table:

Healthy Options (HO) Program	Children’s Health Insurance Program (CHIP)
Basic Health + (BH+)	Washington Medicaid Integration Partnership (WMIP)
State-funded General Assistance- (GA)	

A complete list of the contracted MCOs, acronyms, and the counties they serve can be found in the Appendix.

If an AI/AN client wants to receive medical services from an IHS or Tribal 638 facility, the client must disenroll from the HO, BH+, WMIP, or CHIP program by calling MACSC at 1-800-562-3022 or by filling out a Managed Care Enrollment/Disenrollment Request form, DSHS 13-778. The Department forms are available online at: <http://www.dshs.wa.gov/msa/forms/eforms.html>.

and sending or faxing the completed form to:

HRSA-Division of Customer Support
 PO Box 45505
 Olympia WA 98504-5505
 FAX: 1-360-725-2144

The Washington Medicaid Integration Partnership (WMIP) Information: In Snohomish County, clients identified as “MINT” in ProviderOne are enrolled in **managed care** and must receive medical, community mental health, and outpatient chemical dependency treatment services through **the MCO** – Molina Healthcare of Washington.

AI/AN Medicaid clients have the option to enroll in the WMIP program, but are not automatically enrolled. If the AI/AN client wants to receive medical services from the IHS or Tribal 638 facility, the client should not enroll in the WMIP program.

To enroll or disenroll from **the WMIP** program, use the Washington Medicaid Integration Partnership Exemption/Disenrollment Request form, DSHS 13-737 **available online at:** <http://www1.dshs.wa.gov/msa/forms/index.html> or call MACSC at 1-800-562-3022.

AI/AN clients may also use the client portal: <http://www.waproviderone.org/> to choose FFS or change managed care plan.

To find out more information on this program go to <http://hrsa.dshs.wa.gov/mip/>.

GA Managed Care

Clients identified as “CMP” in ProviderOne are enrolled in managed care.

Note: Effective November 1, 2009, the GA medical/mental health managed care program has expanded from King and Pierce Counties to statewide. All eligible GA clients will be enrolled in the GA managed care program unless they request an exemption from enrollment. The standard exemptions for AI/AN clients previously listed apply. For more information, please go to: <http://hrsa.dshs.wa.gov/GAUMC/>.

The GA managed care program includes both medical services and a limited mental health benefit. Level One mental health benefits are provided in the Community Health Centers (CHC) through the MCO. Level Two mental health benefits are provided in coordination with the local Community Mental Health Centers and Regional Support Network.

Prepaid Inpatient Health Plan Managed Care

Most Medicaid-eligible clients, including AI/AN, are eligible for state-contracted managed outpatient and inpatient mental health benefits through local Regional Support Networks (RSNs). RSNs determine eligibility based on access to care standards.

With the exception of crisis services, outpatient services must be authorized through the RSN. RSNs contract with community mental health agencies for services. To be eligible for RSN services the client must:

- Be Medicaid eligible;
- Have a **Medicaid State Plan**-covered mental illness; and
- Meet State plan medical necessity standards for mental health services.

All eligible Medicaid clients have the right to an intake evaluation to determine whether medical necessity for additional care exists. To access RSN outpatient services the individual should contact their local RSN and request services. The RSN will refer them to a provider for an intake evaluation. The intake evaluation will determine if there is medical necessity for outpatient level care.

Medicaid eligible clients that require voluntary psychiatric hospitalization should have prior authorization from the RSN. Typically the admitting facility requests the authorization from the client’s RSN prior to admission. The authorization request should be from an mental health professional (MHP). The authorization request will include a clinical consultation between the referring MHP and the RSN to verify that there is current medical necessity for psychiatric inpatient level care. All RSNs have 24/7 capacity to receive and process authorization requests.

Client Eligibility

Who Is Eligible?

Please see the Department /HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Payment

Medical Coverage Groups Eligible for the Encounter Rate

Facilities are eligible for payment at the encounter rate for services, if the services are provided at IHS facilities or Tribal 638 facilities for clients on the following medical coverage groups, by an eligible rendering provider.

Note: Limitations for encounter payment for the specific medical service categories are noted in the Medical Service Category column.

Medical Coverage Group Identifier	Medical Coverage Group	Public Assistance Type	Explanation of Medical Care Coverage
F01	Family	Cash and Medical	TANF cash, CN medical
F02	Family	Short-term Medical Extensions	Up to 12 months CN coverage
F03	Family	Short-term Medical Extensions	4 months CN coverage
F04	Family Related	Medical	CN
F05	Newborn – Apple Health for Kids	Medical	CN for Newborns born to moms eligible for or currently Medicaid on date of delivery
F06	Apple Health for Kids	Medical	Children’s CN up to age 19 (No CD encounter)
F10	Family Related	Medical	One month CN certification for individuals who will be eligible for F04 after that month
F99	Apple Health for Kids (with spenddown)	Medical Assistance Only	MN
P02	Pregnancy related medical	Medical Assistance Only	CN
P04	Alien Pregnant Women		CN scope of care

Tribal Health Program

Medical Coverage Group Identifier	Medical Coverage Group	Public Assistance Type	Explanation of Medical Care Coverage
P99	Pregnancy medical with spenddown		Medically Needy
S01 CN	SSI medical (Aged, Blind, or disabled Adults)	Supplemental Security Income (SSI) Medical	For individuals who receive SSI cash through Social Security Administration CN medical and CN does cover chemical dependency treatment
S02	SSI-related medical (aged, blind, disabled adults)	Medical Assistance Only	CN Pay for Chemical Dependency treatment
S08	Working Disabled		CN scope of care with premiums
S95- MN without spenddown S99-MN with spenddown	Medically Needy	None	MN does cover chemical dependency treatment

***Exception: If the client's eligibility verification check shows CNP with a POB in the ACES Coverage Group Field (undocumented pregnant woman), HRSA will pay fee-for-service only.**

Benefit Service Packages *Not* Eligible for the Encounter Rate

Providers are not eligible to bill at the encounter rate for services provided to clients on the following benefit service packages (BSPs). Providers are paid at the standard fee-for-service (FFS) rate:

- Categorically Needy Program – Emergency Medical Only
- Children's Health Program (non-citizen children)
- DETOX
- General Assistance (GA)
- TAKE CHARGE (Reproductive Health Services)
- Qualified Medicare Beneficiary - Medicare Only

Note: See the *Medicaid Fee-for-Service Program* section for information regarding how providers may get paid for providing services to these clients.

Are Clients Enrolled In an MCO Eligible For Payable Services Provided By an IHS or Tribal 638 Facility?

[Refer to [WAC 388-538-060](#) and [095](#)]

YES - Only a limited number of services are eligible for payment by the Department when provided by an IHS or Tribal 638 facility. If an AI/AN client chooses to receive their medical care through a contracted managed care organization (MCO) in their area, the **ONLY** reimbursable services provided by the IHS or Tribal 638 facility are:

- Chemical dependency treatment;
- Dental care;
- Mental health services; and
- Women's health services.

Exception: HO, BH+, GA-U Managed Care, PCCM, and PIHP clients are not required to obtain a referral from their PCP when seeking women's health services, chemical dependency, dental and mental health services. An AI/AN client enrolled in the WMIP program must obtain a referral from their PCP for mental health services. A referral is not required for chemical dependency treatment (see Section C within these billing instructions) or any non-covered benefit.

When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen. All managed care-covered services must be requested directly through the client's primary care provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them. Refer to the Appendix for a list of contracted MCO acronyms, websites, and telephone numbers.

AI/AN clients who wish to receive all services through a Tribal facility can request to be disenrolled from managed care by calling MACSC at 1-800-562-3022 or by filling out a Managed Care Enrollment/Disenrollment Request form, DSHS 13-778 available online at: <http://www.dshs.wa.gov/msa/forms/eforms.html> and sending or faxing it to:

HRSA-Division of Eligibility and Service Delivery
PO Box 45505
Olympia WA 98504-5505
FAX: 1-360-725-2144

Note: To prevent billing denials, please check the client's **eligibility prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department /HRSA *ProviderOne Billing and Resource Guide* at: [http://hrsa.dshs.wa.gov/download/ProviderOne Billing and Resource Guide.html](http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html) for instructions on how to verify a client's eligibility.

Chemical Dependency Treatment Services: Chemical dependency treatment services are not covered services under the HO, BH+, GA, and CHIP programs. Clients do not need a referral from a PCP to receive an assessment or treatment. Refer to the Client Benefit Inquiry screen in ProviderOne to determine billing capability and appropriate Chemical Dependency Treatment contract.

Maternity Support Services/Infant Case Management: MSS/ICM services are covered by Fee-for-Service and not Managed Care. Clients may self refer.

Dental Care Services: Managed care does not cover dental services. Dental services may be covered Fee-for-Service (FFS) regardless of managed care eligibility. Clients who are enrolled in a Department MCO are **eligible for all Medicaid-covered dental services and the following:**

ABCD Children's Dental Program. Refer to the Client Benefit Inquiry screen in ProviderOne to determine appropriate program coverage and billing capability.

Mental Health Services: Mental health services in Washington State are primarily provided under a managed care system administered by Regional Support Networks (RSNs). AI/AN clients may receive outpatient services provided through IHS or Tribal 638 facilities or through the client's RSN. No referral is necessary. A tribal clinic may also bill for mental health services provided to a non native qualified under the "Clinical Family" definition.

Primary Care Case Management (PCCM): For the client who has chosen to obtain care with a PCCM, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a managed care plan. Clients need no referral from a PCP to be able to receive women's health care services.

Note: To prevent billing denials, please check the client's eligibility prior to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Women enrolled with a PCCM may self-refer for women's health care services to a provider other than the clinic where the woman is enrolled. For more information, see "*How do I bill for services provided to PCCM clients?*" within these billing instructions.

Note: If you treat a client who is enrolled with a PCCM and you are not the client's designated PCCM/PCP, the client was not referred to you by the PCCM/PCP, or you are not providing emergency care or women's health services, you may not receive payment. Contact the PCCM/PCP to get a referral. Newborns of clients who are connected with a PCCM are Fee-for-Service (FFS) until the client chooses a PCCM for the newborn. **Bill all services for the newborn to the Department.**

Encounter vs. Fee-for-Service

How Do I Determine If a Service Qualifies as an Encounter?

For a health care service to qualify as an encounter, it must meet all the following criteria. The service must be:

- Medically necessary.
- Face-to-face.
- Identified in the Medicaid State Plan as a service that is:
 - ✓ Covered by the Department;
 - ✓ Performed by a health care professional within their scope of service.
- Documented in the client's file in the provider's office. Client records must be maintained by the primary health care facility to ensure HIPAA compliance.
- Performed in the health care facility identified on the IHS facility list or at other locations where tribal facility-supported activities are performed by qualified clinic staff. Services provided in any other location must comply with HIPAA provisions regarding confidentiality.

Types of Encounters

The Washington Medicaid State Plan recognizes four types of tribal encounters:

- Medical;
- Dental;
- Mental health; and
- Chemical dependency.

Note: The Department pays a maximum of one encounter for each type of encounter, per day, per client, regardless of the services provided.

Example:

- A physician may not bill for a medical encounter and a psychiatric encounter for the same client on the same day. They are both medical encounters.
- A dental encounter and a physician encounter may be billed on the same day by using **the correct diagnosis and taxonomy.**
- A facility may bill for a second encounter if a client returns due to an emergency.
- A rendering provider may be reimbursed for a maximum of one encounter per client within a 24 hour period for all services provided.

Services That Fall Under Two Encounter Categories - Certain services, such as medication management, may fall under two different types of encounters. However, only one service may be billed for each visit.

Note: Billing for the same service under a different type of encounter is considered duplication of payment.

Serving Multiple Clients Simultaneously - When an individual provider renders services to several clients simultaneously, the provider may count each client as a separate encounter if:

- The service provided is medically necessary;
- Provision of services is documented in each client's health record; and
- The services provided are identified in the client's treatment plan.

This policy also applies to family therapy and family counseling sessions. The limits identified in the Medicaid State Plan apply. With the exception of group therapy, **Bill services separately for each client on separate claim forms.**

Who Is Eligible to Perform Encounter Billable Services?

See the *Definitions & Abbreviations* section for a definition of **Encounter**.

The Department considers an eligible health care professional to be an individual who:

- Meets the training and/or licensure requirements for providing services under the state and federal requirements;
- Is listed as a performing provider on a signed Core Provider Agreement;
- Is performing services within the scope of their practice under state law; and
- Performed services are for medically necessary services in accordance with the Medicaid State Plan.

The services of the following providers are included in the encounter rate:

- Advanced Nurse Practitioners;
- Audiologists;
- Chemical Dependency Professional (Within Certified Chemical Dependency Treatment Facilities);
- Dentists;
- Mental Health Professionals (MHP) (A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW or meets the criteria for a MHP as identified in the State plan);
- Nurse Midwives;
- Occupational Therapists;
- Optometrists;
- Physicians;
- Physician Assistants;
- Physical Therapists;
- Podiatrists;
- Psychiatrists; and
- Speech-Language Pathologists.

Included in the outpatient per visit rate are laboratory and x-ray services provided on-site and medical supplies incidental to the services provided to the client.

The following providers may be eligible for fee-for-service reimbursement:

- Registered Nurse;
- Dental Hygienist;
- Hearing Aid Providers;
- Maternity Support Services Providers;
- Take Charge Providers; and Denturist

Types of Services That Do NOT Qualify as Encounters

Services that are not 100% state-funded health programs are not paid as an encounter. The Department pays for the following services under the fee-for-service (FFS) system (see *Definitions & Abbreviations Section* in these billing instructions).

Benefit Service Package	Medical Program	Medical Service Category
ADATSA	Alcoholism & Drug Addiction Treatment & Support Act	Chemical dependency treatment services may be billed only through a specific contract with HRSA/DBHR
CHP	Children's Health Program (non-citizen children)	Chemical dependency treatment services may be billed with the approval of a CPA for CD services. Services are paid at the fee for service rate.
CNP CHIP	Children's Health Insurance Program	Services are paid at the encounter rate EXCEPT for CD services. Chemical dependency treatment services may be billed with the approval of a CPA for CD services.
GA No out of state care	General Assistance	Medical and chemical dependency treatment services may be billed at the fee for service rate.
QMB Medicare Only	Qualified Medicare Beneficiary – Medicare Only	This program pays for Medicaid premiums and pays for deductibles, coinsurance, and copayments according to Medicaid rules
LCP-MNP Emergency Medical Only	Limited Casualty Program – Medically Needy Program Emergency Medical Only	This is a Medicaid program in which the scope of care is limited to hospital-based services relating to an emergency medical condition.
Take Charge	TAKE CHARGE – Family Planning Program	Medical care services cannot be billed as encounters. Clinics will need a program specific NPI and a billing taxonomy of 261QA0005X to bill for client services.

- Blood draws, laboratory tests, and/or x-rays, are bundled in the encounter fee and are considered as part of the encounter service. Services that are provided outside of an encounter visit are reimbursable at the standard fee-for-service (FFS) rate.
- Health services provided to GA-U, some CHIP, CHP, and ADATSA.
- Case management services. Maternity Support Services/Infant Case Management, HIV/AIDS Case Management.

Services NOT Covered by the Department

The following circumstances, services, and activities are NOT covered by the Department and MUST NOT be billed either as an encounter or Fee-for-Service:

1. Participation in a community meetings or group sessions that are not designed to provide health services.

Examples: Informational sessions for prospective users, health presentations to community groups, school screenings, group outings for recreational purposes, parent teacher association (PTA) meetings, etc., or informational presentations about available health services.

2. Health care services provided as part of a large-scale effort. Providers must not provide a free and in-kind service to the community and bill Medicaid-eligible clients only.

Examples: Mass-immunization program, vision or dental screenings, or a community-wide service program (e.g., a health fair).

3. Vision, dental, health screenings provided for free in a community setting.

The services above cannot be paid by the Department and will be denied payment.

Medical Services

Medical Encounters

Qualified health care practitioners may only bill for services that are within the scope of the practitioner's license. Medicaid-covered services are listed in the corresponding billing instructions for the varying providers. A medical service encounter is a service provided by a tribal facility using the following practitioners. **Service limitations and prior authorization requirements for services apply to all Medicaid clients for applicable Medicaid covered services.** Refer to the Department/HRSA billing instructions web site at: <http://hrsa.dshs.wa.gov/download/BI.html>

Providers eligible to bill the encounter rate for services provided	Refer to the Billing Instructions for a list of Medicaid covered services
Physicians, Physician Assistants, Advanced Nurse Practitioners	Physician-Related Services Billing Instructions
Nurse Midwives	Planned Home Births and Births in Birthing Centers Billing Instructions
Podiatrists	Section E: Podiatric Services in the Physician-Related Services Billing Instructions
Optometrists	Section D: Vision Care Services in the Physician-Related Services Billing Instructions
Psychiatrists	Section E: Psychiatric Services in Physician-Related Services Billing Instructions
Speech-Language Pathologists & Audiologists	Speech/Audiology Program Billing Instructions
Physical Therapists	Physical Therapy Program Billing Instructions
Occupational Therapists	Occupational Therapy Billing Instructions

How Do I Bill For a Medical Service Encounter?

Facilities must:

- Bill using an NPI number with **billing taxonomy of 208D00000X**.
- Submit an 837P HIPAA-compliant transaction or complete the CMS-1500 claim form.
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **an all-inclusive, medical service visit/encounter, place modifier** in field 24D on the CMS-1500 claim form (see example below)
- Use the appropriate ICD-9-CM diagnosis code for the service provided.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	As appropriate
Non-native	T1015-SE	As appropriate

Note: The Department allows 12 psychiatric encounters per client, per calendar year for adults. A claim with a primary ICD-9-CM diagnosis within the range of 290-319 will count as a psychiatric encounter. When billing for medication management, if the primary diagnosis is in the 290-319 range, then it will count as one psychiatric encounter. Please use ICD-9-CM diagnosis V58.83 (encounter for therapeutic drug monitoring) for medication management encounters. Medication management is not subject to the 12 visits per client, per calendar year limitation.

HRSA covers **one medical service encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Exception: If, due to an emergency, the client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

Example: If a client comes in for a routine medical visit, it is considered one encounter, *regardless of how many medical providers the client sees* in the course of the visit. However, if the client leaves and returns for *emergency care*, a second encounter may be billed. Use modifier 59 secondary to your tribal modifier on the CMS-1500 claim form when billing electronically to indicate that it is a separate encounter. The time of the initial and subsequent visit documentation must be present for all encounters.

Medical Fee-for-Service

The **client's categorical eligibility** allows Medicaid providers to bill for ancillary services not covered under the encounter rate (e.g., laboratory services not provided during an encounter visit and eligible services for GA clients).

The Department pays for services under the state's Medical Care Services (MCS) program which includes the:

- General Assistance (GA); and
- Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs.

Covered services under these two programs are limited and are not eligible for the federal encounter rate.

An overview of covered services is available at the Medical Eligibility Website online at: <http://hrsa.dshs.wa.gov/Eligibility/OVERVIEW/MedicalOverviewCoveredServices.htm>.

Please refer to the appropriate set of the Department billing instructions for more information. Tribal facilities must submit a [Core Provider Agreement](#) in order to bill for covered services under these programs. For more information, visit the Department's Tribal web site online at: <http://hrsa.dshs.wa.gov/tribal/>.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the appropriate Department/HRSA billing instructions for the service online at: <http://hrsa.dshs.wa.gov/download/BI.html>.

Diabetes Education Program

Please refer to the Department/HRSA *Diabetes Education Program Billing Instructions* available online at:

http://hrsa.dshs.wa.gov/download/P1%20Billing%20Instructions/Diabetes_Education_BI_P1.pdf

Please contact the Program Manager at the Department of Health;

Department of Health
Diabetes Prevention and Control Program
PO Box 47855
Tumwater, WA 98501-7855
Phone 1-253-395-6758
Fax 1-360-236-3708

Durable Medical Equipment (DME)

What is the purpose of the Wheelchairs, DME, and Supplies Program?

[Refer to [WAC 388-543-1100](#)]

The Department/HRSA Wheelchair, DME, and Supplies program makes available to eligible clients the purchase and/or rental of medically necessary DME equipment and supplies when not included in other payment methodologies (e.g., inpatient hospital DRG, nursing facility daily rate, HMO, or managed health care programs). The federal government deems DME and related supplies as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the home health program; or
- Required under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

The Department may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the Department/HRSA [Wheelchairs, DME, and Supplies Billing Instructions](#) available online at: <http://hrsa.dshs.wa.gov/download/BI.html#W>.

Bill for these services using an approved pharmacy or DME NPI number.

The Department-Approved Family Planning Provider Programs [Refer to [Chapter 388-532 WAC](#)]

- Reproductive Health Services;
- Family Planning Only Services; and
- TAKE CHARGE Services.

How Does the Department Define Reproductive Health Services? [[WAC 388-532-001](#)]

The Department defines reproductive health services as follows:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

Billing/Payment Requirements

A TAKE CHARGE provider must:

- Have a current Department core provider agreement to provide family planning services;
- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to HRSA's TAKE CHARGE program guidelines;
- Complete and submit a TAKE CHARGE application agreeing to the: Administrative Practices; Evaluation and Research Responsibilities; and Clinical Practice Standards; and Participate in the Department specialized training for TAKE CHARGE prior to providing TAKE CHARGE services.

For contract information contact the Take Charge Program Manager at:

TAKE CHARGE Program Manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
1-360-725-1652

For more information on the application process, program requirements, initial application and billing/payment information please refer to the Department/HRSA *Family Planning Provider Billing Instructions* available online at: <http://hrsa.dshs.wa.gov/download/BI.html>.

Maternity Support Services (MSS)/Infant Case Management (ICM) [Refer to [Chapter 388-533](#) WAC]

The purpose of the integrated Maternity Support Services (MSS)/Infant Case Management (ICM) program is to provide enhanced support services to eligible pregnant women through the maternity cycle and for eligible families through the month of the infant's first birthday. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs. This program is collaboratively managed by the Department of Health (DOH) and the Department.

Application Process

For a tribe to bill for MSS/ICM services, the agency must be approved by the Washington Department of Health (DOH), Community and Family Health, and must meet billing policy and eligibility requirements specified in the Department/HRSA current *Maternity Support Services/Infant Case Management Billing Instructions*. A maternity support service is a face-to-face between a MSS/ICM provider and a client during which MSS services are provided. MSS includes assessment, development, implementation and evaluation of plans of care for pregnant women and their infants for up to two months postpartum.

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the Department/HRSA current [Maternity Support Services/Infant Case Management Billing Instructions](#) online at: <http://hrsa.dshs.wa.gov/download/BI.html>.

For tribal programs to receive reimbursement for MSS/ICM services, indicate using a modifier AI/AN or a non-tribal client on the claim:

Client	HCPCS Code and Modifier
AI/AN	XXXXXX - UA
Non-native	XXXXXXXX - SE

MSS/ICM services must be billed with billing taxonomy 171M00000X.

Nondurable Medical Supplies and Equipment (MSE)

What is the purpose of the Nondurable MSE Program?

[Refer to [WAC 388-543-1100](#) and [388-543-2800 \(4\)](#)]

The Department's Nondurable MSE program allows eligible clients to purchase medically necessary MSE that are not included in other payments, such as inpatient hospital diagnosis related group (DRG), nursing facility daily rate, health maintenance organization (HMO), or managed care organizations (MCO). The federal government considers MSE as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the Home Health Program; or
- Required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

The Department may reduce or eliminate coverage for optional services, consistent with legislative appropriations. The Department categorizes MSE as follows:

- Antiseptics and germicides;
- Bandages, dressing, and tapes;
- Blood monitoring/testing supplies;
- Braces, belts, and supportive devices;
- Decubitus care products;
- Ostomy supplies;
- Pregnancy-related testing kits and nursing equipment supplies;
- Supplies associated with transcutaneous electrical nerve stimulators (TENS);
- Syringes and needles;
- Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and
- Miscellaneous supplies.

Bill for these services using an approved pharmacy or DME **NPI and taxonomy**.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the Department/HRSA *Nondurable MSE Billing Instructions* available online at: <http://hrsa.dshs.wa.gov/download/BI.html>.

Pharmacy Services [Refer to [Chapter 388-530 WAC](#)]

What Is the Goal of the Prescription Drug Program?

The operational goal of the Prescription Drug Program is to pay providers for outpatient drugs, devices, and drug-related supplies according to the Department rules and subject to limitations and requirements specified in these billing instructions.

Department programs are governed by federal and state regulations. These billing instructions are intended to help providers comply with the rules and requirements of the program.

Basic things to know:

The Department reimburses for medically necessary drugs, devices, and supplies according to rules in Washington Administration Code (WAC) and the Reimbursement section of these billing instructions.

The Department covers outpatient drugs, including over-the-counter drugs, when:

- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). (Exceptions to this rule are described in Section E of the Department/HRSA *Prescription Drug Program Billing Instructions* available online at: <http://hrsa.dshs.wa.gov/download/BI.html#P>.);
- Approved by the Food and Drug Administration (FDA);
- Prescribed by a provider with prescribing authority who has not had his/her core provider agreement terminated or denied;
- Prescribed for a medically accepted indication;
- Prescribed for an eligible client; and
- Not excluded from coverage under WAC 388-501-0050, 388-530-2100, and Section C of these billing instructions (“What drugs, devices, and supplies are not reimbursed?”).

The Department does not cover drugs:

- Used to treat sexual or erectile dysfunction, in accordance with section 1927(d)(2)(K) of the Social Security Act, unless such drugs are used to treat a condition other than sexual or erectile dysfunction and these uses have been approved by the FDA;
- That is not approved by the FDA;
- Prescribed for a non-medically accepted indication or dosing level;

- From a manufacturer without a federal rebate agreement; or
- Indications excluded from coverage by Washington Administrative Code (WAC) such as drugs prescribed for:
 - ✓ Weight loss or gain;
 - ✓ Infertility, frigidity, or impotence;
 - ✓ Sexual or erectile dysfunction; or
 - ✓ Cosmetic purposes or hair growth.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the Department/HRSA [*Prescription Drug Program Billing Instructions*](#) available online: <http://hrsa.dshs.wa.gov/download/BI.html#P>.

Dental Services

Dental Encounters

A tribal facility may bill the Department for dental services provided to a client, for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. Tribal facilities are required to provide a National Provider Identifier (NPI) number with dental taxonomy.

Qualified practitioners may only bill for services that are within the scope of the practitioner’s license. Medicaid covered services are listed in the corresponding billing instructions for the varying providers. Dental providers can find more detailed information regarding dental programs, prior authorization, and patient release forms at:

- [Dental Program for Clients Age 21 and Older](#)
- [Dental Program for Clients Through Age 20](#)

A dental service encounter is for services provided by a tribal facility using the following practitioners:

Providers eligible to bill the encounter rate for services provided	Refer to these Billing Instructions for Medicaid covered services
Dentists	<i>Dental Program for Clients Age 21 and Older,</i>
	<i>Dental Program for Clients Through Age 20,</i> and the
	<i>Orthodontic Billing Instructions</i>

How Do I Bill For a Dental Services Encounter?

Facilities must:

- **Bill using an NPI number with the billing taxonomy of 122300000X.**
- Submit an 837P transaction or complete the CMS-1500 Claim Form.
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **an all inclusive dental services visit/encounter.**
- Use ICD-9-CM diagnosis codes 520 through 525.9 or V72.2.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	520-525.9 or V72.2
Non-native	T1015-SE	520-525.9 or V72.2

HRSA covers **one dental encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

Example: If a client comes in for a routine cleaning and x-rays, it is considered one dental encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, chips a tooth, and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. Use field 19 on the CMS-1500 form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation must be present for all encounters.

Dental Fee-for-Service [Refer to [Chapter 388-535 WAC](#)]

Please see the Department/HRSA current *Dental Billing Instructions* for covered services and appliances for children and adults at:

- [Dental Program for Clients Age 21 and Older](#); and
- [Dental Program for Clients Through Age 20](#).

The dental National Provider Identifier (NPI) number allows Medicaid providers to bill for dental services and appliances (e.g. denture services and orthodontic services) not covered under the encounter rate. The Department requires *prior authorization* for many dental services.

Clients - 20 years of age and younger

The Department covers the following:

- One complete denture only, including an immediate denture or overdenture per client in a five year period, or
- Replacement of an immediate denture with a complete denture only when the replacement occurs at least six months after the seat date of the immediate denture.

Note: The Department requires prior authorization for any set of dentures.

The Department requires the Denture or Partial Denture Agreement of Acceptance form, DSHS 13-809 for all completed dentures. This form can be downloaded online at:

<http://www.dshs.wa.gov/msa/forms/eforms.html>

Partial denture coverage includes:

Resin Partial Dentures

- Authorization *is required* for clients age nine and younger; and
- Authorization is *not* required for clients ages 10-20. Documentation supporting the medical necessity for the service must be included in the client's file.

Note: The Department covers replacement of a resin partial only if prior authorized at least three years after the seat date of the replacement partial denture.

Cast-metal Framework Partial Dentures

- Are covered only one time in a five year period for clients 18-20 years old with Prior Authorization; and
- Are *not covered* for clients age 17 and younger.

The Department requires the Denture or Partial Denture Agreement of Acceptance form, DSHS 13-809 for all cast metal partial dentures. This form can be downloaded online at:

<http://www.dshs.wa.gov/msa/forms/eforms.html>

Note: The complete criteria for children's dentures can be reviewed in the *Dental Program for Clients through Age 20* billing instructions.

Clients - 21 years of age and older

The Department covers the following for eligible adults **with prior authorization (PA)**:

Dentures

- Only one complete denture, including an immediate denture or overdenture per client in a five year period, or
- Replacement of an immediate denture with a complete denture only when the replacement occurs at least six months after the seat date of the immediate denture.

The Department requires a completed signed copy of the Denture or Partial Denture Agreement of Acceptance form, DSHS 13-809 by the client be attached to a claim form and sent to the Department's dental authorization for release of the authorization number to allow payment of the claim.

The dentures must be of an acceptable structure and quality to meet the standard of care. The Department does not cover transitional dentures.

The Department requires prior authorization for all covered Orthodontic services. See the *Orthodontic Services Billing Instructions* for complete details.

Resin Partial Dentures

The Department covers partial dentures, as follows:

- A resin base partial denture for anterior and posterior teeth according to the Department coverage criteria, or
- Replacement of a resin base partial denture only when the replacement occurs at least three years after the seat date of the partial denture being replaced.

Cast-metal Framework Partial Dentures

- A cast-metal framework with resin-base partial denture per the Department coverage criteria, or
- Replacement of a cast-metal framework resin base partial denture only when the replacement occurs at least five years after the seat date of the partial denture being replaced.

The Department requires the Denture or Partial Denture Agreement of Acceptance form, DSHS 13-809 for all cast metal partial dentures.

See the complete criteria for adult dentures and partials in the Dental Program for Clients Age 21 and Older billing instructions.

(See exception for laboratory and professional fees for dentures and partials in each billing instructions)

Orthodontics

The Department only covers orthodontic treatment and orthodontic-related services for clients through the age of 20. Services covered for eligible clients include:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement; or
- Severe dental malocclusions.

Note: The Department requires prior authorization for all covered Orthodontic services. See the Orthodontic Services billing instructions for complete details.

The Department does not cover orthodontic services for cosmetic purposes.

Prior Authorization (PA)

General Information about Authorization

- The Department uses the determination process for payment described in WAC 388-501-0165 for covered dental-related services that require PA.
- When the Department authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment.
- The authorization is valid for six months and only if the client is eligible for covered services on the date of service.
- Authorization must take place before the service is provided.

How do I obtain written prior authorization PA?

- The Department requires sufficient information to establish medical necessity.
- Submit the request in writing on a completed ADA Claim Form to include:
 - ✓ The client's ID number;
 - ✓ Provider's name and address;
 - ✓ Provider's telephone number; and
 - ✓ Provider's NPI number.
- The Department may request additional information:
 - ✓ Additional radiographs (x-rays);
 - ✓ Study model if requested;
 - ✓ Photographs; and
 - ✓ Any other information requested by the Department.

Where do I send requests for PA?

The Department will accept requests for prior authorization (PA) that utilize access to electronic review of x-rays, periodontal charts, intraoral photos, and other supporting documentation.

Providers that do not utilize electronic back up must send requests and documentation to;

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs fax documentation to 1-360-725-2123

Note: For complete authorization information review either of the current Department/HRSA Dental Program billing instructions.

Dental Coverage under State-Funded Programs

The Dental NPI number allows payment for the limited coverage for dental-related services provided under state-only funded programs. Clients who receive MCS under the following state-funded only programs receive the limited coverage described below:

- GA.
- ADATSA - GA-W.

The Department covers the dental-related services described and limited in these billing instructions for clients eligible for GA or GA-W only when services are provided as part of a medical treatment for:

- Apical abscess verified by clinical examination and radiograph(s), and treated by any of the following:
 - ✓ Palliative treatment (e.g., open and drain, open and broach).
 - ✓ Tooth extraction.
 - ✓ Root canal therapy for permanent anterior teeth only.
- Tooth fractures (limited to extraction).
- Total dental extraction prior to and because of radiation therapy for cancer of the mouth.

Dental NPI number may be used to bill dental codes using the on an ADA (version 2006) dental form or 837D transaction.

Mental Health Services

Mental Health Encounters

A mental health encounter is a medically necessary, face-to-face contact between a mental health professional (MHP) and a client during which services are provided.

Services are provided by an MHP to adults and children and when mental health services are determined to be medically necessary **as defined in the Medicaid State Plan**. These services must be provided to reach the goals of an Individualized Service Plan. Medical necessity is determined by a mental health professional. All Medicaid State Plan modality services are accessible based on clinical assessment, medical necessity, and individual need. An appropriate Individual Service Plan will be developed between an eligible individual and their mental health care provider, **and if younger than the age of consent, a parent or custodial adult**.

Services are provided at locations convenient to the consumer, by or under the supervision of a MHP. HIPAA compliance must be maintained for all services. Tribal facilities may choose to provide services to “clinical family members”.

The following are services that may be provided **by an eligible Indian Health Service (IHS) 638 facility that has an approved Core Provider Agreement for mental health services with DSHS, and when provided by eligible rendering providers in accordance with each modality (please see Appendix for service definitions):**

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and
- Therapeutic psycho-education.

To see a table listing modalities and eligible providers, refer to the table in the Appendix.

Who Is Eligible To Receive The Mental Health Encounter Rate?

To receive reimbursement for a mental health encounter, the tribal program must:

- Be on the Indian Health Service (IHS) facility list and identified to provide behavioral health services;
- **Must meet state standards as a Mental Health Program or have national accreditation;**
- Be included in the category of mental health professionals (as defined in WAC 388-865-0150); and
- **Be providing services within their scope of practice.**

The table below includes categories of mental health professionals (as defined in [WAC 388-865-0150](#)) **Master's level providers are as follows:**

• Psychiatrists;	• Psychologists;
• Social workers;	• Child psychiatrists;
• Psychiatric nurses; and	• Counselors.

Refer to [WAC 388-865-0265](#), [RCW 71.05](#), and [RCW 71.34](#) for more information about mental health professionals and licensure requirements.

How Do I Bill For a Mental Health Encounter?

Facilities must:

- **Bill using an NPI number with the billing taxonomy of 2083P0901X;**
- Submit an 837P transaction or a completed CMS-1500 claim form;
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **an all inclusive mental health services visit/encounter.**

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-HE	As appropriate
Non-native*	T1015-SE	As appropriate

The Department covers **one mental health encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Example: If a client comes in for a routine therapy visit, it is considered one Mental Health encounter, regardless of how many providers the client sees in the course of a 24-hour period. If a client leaves and returns for emergency care, that is a second diagnostic a second encounter may be billed. (Use mod 59) Use field 19 on the CMS-1500 form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation is required for all encounters.

Psychiatric Service Encounters (Specialized Medical Encounter)

Qualified practitioners may only bill for services that are within the scope of the practitioner’s license. Medicaid covered services are listed in the corresponding billing instructions for the varying providers. A psychiatric service encounter is a specialized medical service provided by a tribal facility using a psychiatrist. (Bill medication management as a medical encounter)

The Department limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, for up to a total of 12 hours per calendar year (this includes family or group psychotherapy).

Providers eligible to bill the encounter rate for services provided	Refer to these Billing Instructions for Medicaid covered services
Physicians, Physician Assistants , Advanced Nurse Practitioners	<u>Physician –Related Services Billing Instructions</u>
Psychiatrists	See Psychiatric Services section in the <u>Physician –Related Services Billing Instructions</u>

How Do I Bill for a Psychiatric Services Encounter?

Facilities must:

- Bill using an NPI number with **the billing taxonomy of 2084P0800X**; and
- Submit an 837P transaction or complete the CMS-1500 claim form.

Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **an all inclusive psychiatric services visit/encounter**. Use ICD-9-CM diagnosis codes 290 through 319 (mental disorders).

Note: The Department allows 12 psychiatric encounters per calendar year for adults 21 years of age and older and 20 encounters for children. A claim with a primary ICD-9-CM diagnosis within the range of 290-319 will count as a psychiatric encounter. When billing for medication management, a primary diagnosis in the 290-319 range, will count as one psychiatric encounter. Please use ICD-9-CM diagnosis V58.83 (encounter for therapeutic drug monitoring) for medication management encounters. Medication management is not subject to the 12 visits per calendar year limitation.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	290-319
Non-native	T1015-SE	290-319

The Department covers **one psychiatric service encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Exception: If, due to an emergency, a client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

Example: If a client comes in for a routine therapy visit, it is considered one Psychiatric encounter, regardless of how many providers the client sees in the course of the visit. If a client is seen by the psychiatrist for psychotherapy and also sees a provider for medication or medical management, it is considered to be one medical encounter visit. However, if the client leaves and returns for *emergency care*, a second encounter may be billed. Use field 19 on the CMS-1500 Claim Form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation is required for all encounters.

Chemical Dependency and Treatment Services

Chemical Dependency Encounters

A chemical dependency encounter is a face-to-face contact between a qualified Chemical Dependency Professional (CDP) and a Medicaid beneficiary when services are provided for outpatient alcohol and/or drug treatment services as defined in [Chapter 388-805 WAC](#).

Who Is Eligible To Bill for a Chemical Dependency Encounter?

Services must be provided by a CDP certified by the Department of Health (DOH) under [RCW 18.205](#) (or a CDP trainee) and as defined in [Chapter 388-805 WAC](#). Services must be provided by a tribal treatment facility approved by the Department pursuant to [Chapter 388-805 WAC](#) and [RCW 70.96.A](#). To be paid for chemical dependency treatment services, the tribe must have a Core Provider Agreement with the Department to provide these services.

Payment for a Chemical Dependency Encounter

The Department pays tribal facilities the full encounter rate for chemical dependency treatment services provided to Medicaid **eligible** AI/AN clients. The Department pays tribal facilities that provide chemical dependency treatment services to non AI/AN Medicaid clients at the encounter rate when a tribe provides the required state matching funds. The Department **reimburses** only the federal portion of the encounter rate for each encounter provided to non-AI/AN **clients**. **In order to be reimbursed for services to non-AI/AN Medicaid clients, the match dollars must be deposited into an account in the Office of the State Treasurer (OST) to be used for match funds for CD services. The state can then draw upon the account to provide** local match. The Department will reimburse the tribes by returning both the tribal match dollars and federal match.

What Is the Process for an IGT?

The local match is calculated for the month of service that is being billed by applying the difference of the current FMAP rate minus 100%.

This can be found in the latest # memo identifying the current OMB/IHS encounter rate and current Medicaid FMAP. Tribes submit billings into ProviderOne for CD services for non-natives. The cutoff for each month of service is the 15th of the following month. Tribes would calculate the local match for the month of service that is being billed by applying the difference of the current FMAP rate. Send the local match by using one of three options outlined below:

1. Electronic Funds Transfer (EFT) or Wire transfer – Prior to sending the EFT/Wire to the Department of Social and Health Services, please send an e-mail to Charles Osborn at Charles.Osborn@dshs.wa.gov notifying of the transfer. Include the amount of transfer and date. The Account Number for the Department is: 105000000617. The EFT/Wire Routing Number is 026009593.
2. Automated Clearing House (ACH) transfer – Prior to sending the EFT/Wire to the Department, please send an e-mail to Charles Osborn at Charles.Osborn@dshs.wa.gov notifying of the transfer. Include the amount of transfer and date. The Account Number for the Department is: 105000000617. The EFT/Wire Routing Number is 123308825.
3. Submit a check for the amount of match.

Note: The process takes longer if a check is used for payment rather than paying electronically.

If using a check, please send to:

**The Department of Social and Health Services –
Health & Recovery Services Administration
Attention: Division of Rates and Finance Director
PO Box 45500
Olympia, WA 98504-5500**

- The Department will send a confirmation notice to the tribe if funds were received;
- The Department will set up individual revenue account to track these deposits from each tribe;
- The Department will draw down federal match for these claims;
- The Department will issue payment within 5 to 7 business days (both state and federal) to tribes via EFT and use statewide vendor numbers;

- For audit purposes, reconciliation by the Department will be completed every 3 months to ensure the state match **received** is equal to the state match **required** for federal claiming. The Department will work with the tribes on this reconciliation and formally notify the tribes via e-mail.

Tribes may contract with county governments to provide chemical dependency treatment services to non-AI/AN Medicaid clients. Tribes that choose to contract with county governments are paid at the usual and customary Fee for Service rates paid to any other provider.

The facility may only bill for services defined in [Chapter 388-805 WAC](#).

Clarification for Service Reimbursement

Services that fall under two encounter categories: If a health care professional who is dually certified as a CDP and a mental health professional provides a service, you may bill the service as only one encounter. Billing for the same service under a separate category is considered duplication of payment.

Courtesy Dosing

Courtesy dosing between Opiate Substitution providers is reimbursed at the usual and customary fee-for-service rate. Please note the following steps:

- Determine if the intended receiving clinic will courtesy dose.
- Provide the receiving clinic with the courtesy dosing form prior to the client’s arrival at the clinic.
- After the courtesy dosing period, the receiving clinic will bill for the days dosed.

How Do I Bill for a Chemical Dependency Encounter?

Facilities must:

- **Bill using an NPI number with the billing taxonomy of 261QR0405X.**
- Submit an 837P transaction or complete the CMS-1500 claim form.
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier for **an all inclusive Chemical Dependency Treatment visit/encounter.**

Client	HCPCS Code and Modifier
AI/AN	T1015-HF
Non-native	T1015-HX - If the tribe has set up an account to provide the appropriate matching funds.

Coverage Table

Division of Behavioral Health and Recovery Alcohol and Drug Treatment Outpatient Services

Note: Billing for Chemical Dependency Disposition Alternative (CDDA) locally sanctioned and CDDA committable services is restricted to providers who are contracted to provide services to CDDA youth through a Juvenile Rehabilitation Administration (JRA) contract.

Visit the Department on-line for a current fee schedule at:

<http://hrsa.dshs.wa.gov/RBRVS/index.html#c>.

Procedure Codes- Modifier		HCPCS/ CPT Code Description	Service	Taxonomy Code
General	CJTA * Funded			
H0003-HF		Alcohol and/or drug screening	CA Initial Screening	261QR0405X
H0001-TG		Alcohol and/or drug assessment, complex/high tech level of care	DCFS Expanded Chemical Dependency Assessment	261QR0405X
H0001-HF	H0001-HZ	Alcohol and/or drug assessment, substance abuse program	Chemical Dependency Assessment	261QR0405X
H0001-HD		Alcohol and/or drug assessment, pregnant/parenting women's program	Pregnant & Postpartum Women Assessment	261QR0405X
H0002-HF	H0002-HZ	Screening for admission to treatment program	Intake Processing	261QR0405X
H2033 - HF	H2033 - HZ	Multisystemic therapy for juveniles, per 15 minutes	18-20 year old determined better served in Group Therapy - Youth Outpatient Facility. Limited to 3 hours per day.	261QR0405X

Tribal Health Program

Procedure Codes- Modifier		HCPCS/ CPT Code Description	Service	Taxonomy Code
General	CJTA * Funded			
96154-HF	96154-HZ	Health and behavior intervention, family with patient present	Individual Therapy with Client Present	261QR0405X
96155-HF	96155-HZ	Health and behavior intervention, family with patient present	Individual Therapy Without Client Present	261QR0405X
96153-HF	96153-HZ	Health and behavior intervention, group	Group Therapy	261QR0405X
T1017-HF	T1017-HZ	Targeted case management, each 15 minutes	Case Management	251B00000X
H0020-HF	H0020-HZ	Methadone administration and/or service	Opiate Substitution Treatment	261QM2800X
86580	86580	Tuberculosis test intradermal	Tuberculosis Testing	261QR0405X

Coverage/Limitations Table

COVERAGE	LIMITATION
Acute Detoxification Services	<ul style="list-style-type: none"> • Covered once per day, per patient. • Covered up to a maximum of 3 consecutive days for alcohol detoxification. • Covered up to a maximum of 5 consecutive days for drug detoxification.
Case Management	<ul style="list-style-type: none"> • Covered up to a maximum of 5 hours per calendar month per patient. • One unit equals 15 minutes. • Must be provided by a certified Chemical Dependency Professional (CDP) or Chemical Dependency Professional Trainee CDPT. • Cannot be billed for the following activities: outreach, time spent reviewing a certified CDP Trainee’s file notes, internal staffing, writing treatment compliance notes and progress reports to the court, interactions with probation officers, and court reporting.
Chemical Dependency Assessment	<ul style="list-style-type: none"> • Covered once per treatment episode for each new and returning patient. <p>Note: Do not bill updates to assessments or treatment plans as separate assessments.</p>
CA Initial Screen	<ul style="list-style-type: none"> • Covered once per patient. • Do not bill if the Expanded Assessment has been completed and billed or until 60 days after the screen was completed, the sample collected, and the patient did not return to complete the assessment. • Covered only as a component of an expanded assessment for CA-referred clients.
Expanded Chemical Dependency Assessment	<ul style="list-style-type: none"> • Covered for new and returning patients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services by the same agency. • If an Initial Screen has been billed for a Division of Children & Family Services (DCFS) referred patient, the billing for the expanded assessment must be reduced by the amount of the initial screen, as the Initial Screen is a component of the expanded assessment for a DCFS patient.
Intake Processing	<ul style="list-style-type: none"> • Covered for new and returning patients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services, except for an assessment, by the same agency.

COVERAGE	LIMITATION
<p>Individual Therapy - DBHR Contracted Providers</p>	<ul style="list-style-type: none"> • Covered up to a maximum of 3 hours per day, per patient. • Individual therapy is covered only when provided for a minimum of 15 minutes. • One unit equals 15 minutes. After the first 15 minutes, each additional unit is billed after it is begun rather than after it is finished (ex: when a session lasts 17 minutes it is billed as two units). <p>Note: When family members attend an individual session either in lieu of, or along with, the primary patient, the session may be claimed only once regardless of the number of family members present.</p>
<p>Individual Therapy Full Visit- JRA</p>	<ul style="list-style-type: none"> • One unit covered per day, per client. • One unit equals one hour. • Individual therapy is covered only when provided for a minimum of one hour. • Billable only for providers who hold contracts established through JRA. <p>Note: When family members attend an individual session either in lieu of or along with the primary patient, the session may be claimed only once regardless of the number of family members present.</p>
<p>Individual Therapy Brief Visit - JRA</p>	<ul style="list-style-type: none"> • Covered once per day, per client. • A session of 15 minutes to 45 minutes in duration constitutes a brief visit. • Billable only for providers who hold contracts established through JRA. <p>Note: When family members attend an individual session either in lieu of or along with the primary patient, the session may be claimed only once regardless of the number of family members present.</p>
<p>Intensive Youth Case Management - JRA</p>	<ul style="list-style-type: none"> • Covered once per calendar month for clients younger than 21 years of age. • Services may be performed only for youth in the CDDA program by the providers identified by JRA and who hold contracts established through JRA.

COVERAGE	LIMITATION
Group Therapy	<ul style="list-style-type: none"> • Covered up to a maximum of 3 hours per day. • Claims for group therapy may be made only for eligible patients or their families within the group. • One unit equals 15 minutes. • Group therapy is covered only when provided for a minimum of 45 minutes (3 units) up to a maximum of 3 hours (12 units) per patients, per day. <p>Note: When family members attend a group therapy session either in lieu of or along with the primary patient, the session may be claimed only once regardless of the number of family members present.</p>
Opiate Substitution Treatment	<ul style="list-style-type: none"> • Covered once per day while a patient is in treatment.
Opiate Treatment Program Courtesy Dosing	<p>Courtesy dosing between Opiate Substitution providers is reimbursed at the usual and customary fee-for-service rate. Please note the following steps:</p> <ul style="list-style-type: none"> • Determine if the intended receiving clinic will courtesy dose. • Provide the receiving clinic with the courtesy dosing form prior to client’s arrival at the clinic. • After the courtesy dosing period, the receiving clinic will bill for the days dosed.
Sub-Acute Detoxification Services	<ul style="list-style-type: none"> • Covered once per day, per client. • Covered up to a maximum of 3 consecutive days for alcohol detoxification. • Covered up to a maximum of 5 consecutive days for drug detoxification.
Tuberculosis (TB) Testing	<ul style="list-style-type: none"> • TB testing is a covered service when provided by a licensed practitioner within the scope of his/her practice as defined by state law or by the Department of Health, Washington Administrative Code (WACs), or as provided by a tuberculosis community health worker approved by the DOH.
Urinalysis-Drug Testing	<ul style="list-style-type: none"> • Urinalysis-drug testing is covered only for methadone patients and pregnant women. • Treatment agencies must establish protocols with DBHR’s contracted provider laboratory to send UAs to the laboratory. • The Department pays for UAs only when provided by a DBHR's contracted provider. • Limit of four (4) UAs per month while actively in treatment services. Call DBHR at 1-877-301-4557 for more information.

Do not bill for case management or intensive case management under the following situations:

- If a pregnant woman is receiving Infant Case Management (ICM) services under the Department's MSS/ICM Program;
- If a person is receiving Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) case management services through the Department of Health (DOH);
- If a youth is on parole in a non-residential setting and under the Juvenile Rehabilitation Administration's (JRA) supervision. Youth served under the Chemical Dependency Disposition Alternative (CDDA) program are **not** under JRA supervision;
- If a youth is in foster care through the Division of Children and Family Services (DCFS); and
- If a person is receiving case management services through any other funding source from any other Department system (i.e. person enrolled in Mental Health with a Primary Health Provider).

(Billing for case management under these situations is prohibited because federal financial participation is being collected by the Department, DOH, DCFS, JRA, or the Division of Behavioral Health and Recovery (DBHR) for these clients.)

Billing

What Are the General Billing Requirements?

Providers must follow the Department's *ProviderOne Billing and Resource Guide* at <http://hrsa.dshs.wa.gov>. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- The fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Third-party liability; and
- Record keeping requirements.

What Are the Record Keeping Requirements Specific to Chemical Dependency Treatment Providers?

- A chemical dependency assessment and history of involvement with alcohol and other drugs;
- Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews;
- Date, duration, and content of counseling and other treatment sessions;
- Progress notes as events occur, and treatment plan reviews as specified under each treatment service or [Chapter 388-805 WAC](#);
- Release of information form signed by the patient to share information with the Department;
- A copy of the continuing care plan signed and dated by the CDP and the patient; and
- The discharge summary.

Note: The Department may ask for documentation of medically necessary services signed by a health care provider.

State Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is jointly financed by the federal and state governments and is administered by the Department. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit service packages, payment levels for coverage, and administrative and operating procedures. Under CHIP, the federal government provides a capped amount of funds to each state on a matching basis. Federal payments under title XXI to states are based on state expenditures under approved plans. Washington State exempts premiums for AI/AN CHIP clients of federally recognized tribes.

Title XXI of the Social Security Act (CHIP authorization) does not have 100% federal match provisions for CHIP services provided to AI/AN children by tribal facilities. States can claim the enhanced CHIP match rate (currently 65% for Washington) for such services.

Note: Bill the Department for medical, dental, and mental health services provided to clients who have a verified CHIP identifier for their Benefit Services Package the same way you would bill for any other Medicaid-eligible client.

Chemical Dependency

The Division of Behavioral Health and Recovery (DBHR) uses the regular fee-for-service (FFS) payment rate for CHIP clients.

Tribal facilities may contract with county governments to provide chemical dependency treatment services for CHIP clients. Tribal facilities that choose to contract with county governments for CHIP clients will be paid at the standard FFS rate.

The Tribal facility may also contract directly with DBHR to provide services to CHIP clients. Tribal facilities may provide chemical dependency treatment services for CHIP clients who are AI/AN. The Tribe may be reimbursed for services to non-native clients provided that the non-federal matching funds are submitted to the state.

Medical and Dental

The Department uses the Medicaid encounter rates to pay tribal facilities for permissible Title XXI services provided to CHIP AI/AN and non native children who are not enrolled in managed care. The Department also uses the Medicaid encounter rates to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for permissible Title XXI services provided to CHIP children.

AI/AN clients enrolled in CHIP have the option to receive their medical care through the state's contracted managed care organizations (MCOs). The MCO in which they are enrolled is identified in the client eligibility screen in ProviderOne.

AI/AN may choose to be seen at a tribal clinic for their medical, dental, and mental health services. If the clinic chosen has a Primary Care Case Management (PCCM) contract the client will be enrolled as a PCCM client. If the clinic does not have a PCCM contract the client is enrolled as Fee-for-Service (FFS). A complete list of the contracted MCOs, acronyms, and the counties they serve can be found in the Appendix.

Mental Health

AI/AN clients may choose to be seen at a tribal clinic for their medical, dental, and mental health services. The Department uses the Medicaid encounter rates to pay tribal facilities for permissible Title XXI services provided to CHIP AI/AN children. For non native CHIP clients requesting services at a tribal facility, the CHIP client needs to qualify as a "clinical family member" for the tribe to be paid for the service. If the client does not meet the criteria for payment, the clinic should refer the client to the RSN.

Administrative Contract Programs

Medicaid Administrative Match (MAM)

The Medicaid Administrative Match (MAM) program provides reimbursement to governmental agencies including tribes for administrative-related activities for Medicaid eligible people.

Examples of reimbursable activities include: outreach, coordination, and referral of Medicaid eligible individuals to Medicaid services.

For more information, please contact the Administrative Match Unit Manager at 1-360-725-1647.

You may also visit the MAM web site online at:
<http://hrsa.dshs.wa.gov/mam/Index.htm>

Primary Care Case Management (PCCM)

The PCCM contract was developed as an alternate resource for federally recognized tribal members who are eligible for the Healthy Options (HO) Program and for tribal clinics. This contract is available to tribal clinics interested in providing case management services to federally recognized tribal members eligible for HO. The contract allows the clinic to bill the encounter rate for treatment services to Medicaid-eligible clients and be paid for case management services. PCCM client services are paid at the standard rate.

For more information please call 1-360-725-1649.

Completing the CMS-1500 Claim Form

General Information

Note: The Department encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 claim form instructions relate to *Chemical Dependency Treatment*. Click the link above to view general CMS-1500 claim form instructions.

For questions regarding claims information, refer to the *Important Contacts* section.

Field No.	Name	Entry												
24B.	Place of Service	<p>The following are the only appropriate codes for Washington State Medicaid:</p> <table border="0"> <thead> <tr> <th><u>Code Number</u></th> <th><u>To Be Used For</u></th> </tr> </thead> <tbody> <tr> <td>07</td> <td>Tribal 638 free-standing facility</td> </tr> <tr> <td>08</td> <td>Tribal 638 provider</td> </tr> <tr> <td>50</td> <td>Federally Qualified Health Center (FQHC)</td> </tr> <tr> <td>55</td> <td>Residential Substance Abuse Treatment Facility</td> </tr> <tr> <td>57</td> <td>Non-residential Substance Abuse Treatment Facility</td> </tr> </tbody> </table> <p>Note: Place of Service codes have been expanded to include all places of service related to providing chemical dependency treatment services.</p>	<u>Code Number</u>	<u>To Be Used For</u>	07	Tribal 638 free-standing facility	08	Tribal 638 provider	50	Federally Qualified Health Center (FQHC)	55	Residential Substance Abuse Treatment Facility	57	Non-residential Substance Abuse Treatment Facility
<u>Code Number</u>	<u>To Be Used For</u>													
07	Tribal 638 free-standing facility													
08	Tribal 638 provider													
50	Federally Qualified Health Center (FQHC)													
55	Residential Substance Abuse Treatment Facility													
57	Non-residential Substance Abuse Treatment Facility													

Field No.	Name	Entry
24E.	Diagnosis Code	<p>The primary diagnosis codes 30500 (for alcohol abuse) or 30590 (for drug abuse) may be used only when billing for assessments for youth and pregnant women.</p> <p>For all other clients, diagnosis codes 30390 or 30490 must be used when billing for assessments. The diagnosis code does not reflect the outcome of the assessment or the diagnosis of the patient.</p> <p>Treatment services will be reimbursed for clients with a dependency diagnosis. Use 30390 (alcohol) or 30490 (drug) diagnosis codes.</p>

Treatment services for youth and pregnant women with a diagnosis of abuse are reimbursed with either State Grant in Aid or Substance Abuse Prevention and Treatment Block Grant funds.

Appendix

Eligibility Verification of Managed Care Plans and Plan Contact Information

Eligibility Check Acronym	Plan Name	Plan Phone	Plan Web Site	Department Programs
ANH	Asuris Northwest Health Plan	1-888-344-5587	www.asuris.com	Healthy Options
CHPW CHPP CHPG	Community Health Plan of Washington	1-800-440-1561	www.chpw.org	Healthy Options Basic Health Plus GAU Managed Care
CUP CUPP	Columbia United Providers	1-800-315-7862	www.cuphealth.com	Healthy Options Basic Health Plus
EVCP	Evercare Premier	1-866-266-0636	www.evercareonline.com	Medicare/ Medicaid Integration Project
GHC GHP	Group Health Cooperative	1-888-901-4636	www.ghc.org	Healthy Options Basic Health Plus
KHPP	Kaiser Foundation Health Plan	1-800-813-2000	www.kaiserpermanente.org	Basic Health Plus
MHC MHCP MINT	Molina Healthcare of Washington	1-800-869-7165	www.molinahealthcare.com	Healthy Options Basic Health Plus Washington Medicaid Integration Partnership

Tribal Health Program

Eligibility Check Acronym	Plan Name	Plan Phone	Plan Web Site	Department Programs
RBS	Regence Blue Shield	1-800-669-8791	www.wa.regence.com	Healthy Options
ANH	Asuris Northwest Health Plan	1-888-344-5587	www.asuris.com	Healthy Options
CHPW CHPP CHPG	Community Health Plan of Washington	1-800-440-1561	www.chpw.org	Healthy Options Basic Health Plus GAU Managed Care
CUP CUPP	Columbia United Providers	1-800-315-7862	www.cuphealth.com	Healthy Options Basic Health Plus
EVCP	Evercare Premier	1-866-266-0636	www.evercareonline.com	Medicare/Medicaid Integration Project
GHC GHP	Group Health Cooperative	1-888-901-4636	www.ghc.org	Healthy Options Basic Health Plus
KHPP	Kaiser Foundation Health Plan	1-800-813-2000	www.kaiserpermanente.org	Basic Health Plus
MHC MHCP MINT	Molina Healthcare of Washington	1-800-869-7165	www.molinahealthcare.com	Healthy Options Basic Health Plus Washington Medicaid Integration Partnership
RBS	Regence Blue Shield	1-800-669-8791	www.wa.regence.com	Healthy Options

**Medicaid State Plan: Department/HRSA
Tribal Mental Health Benefit
Tribal Provider Staff Eligible to Bill the Encounter Rate**

	Benefit/Service Modality	Eligible to Bill Encounter	Eligible to Bill Fee for Service
1	Brief Intervention Treatment	MHPs*	MHCP** under MHP Supervision
2	Crisis Services	MHPs*	MHCP** under MHP Supervision
3	Day Support	MHPs*	MHCP** under MHP Supervision
4	Family Treatment	MHPs*	MHCP** under MHP Supervision
5	Freestanding Evaluation and Treatment	MHPs*	MHCP** under MHP Supervision
6	Group Treatment Services	MHPs*	MHCP** under MHP Supervision
7	High Intensity Treatment	MHPs*	MHCP** under MHP Supervision
8	Individual Treatment Services	MHPs*	MHCP** under MHP Supervision
9	Intake Evaluation	MHPs*	MHP only
10	Medication Management	Persons licensed to prescribe and/or administer and review medications.	Persons licensed to prescribe and/or administer and review medications.
11	Medication Monitoring	MHPs*	MHCP** under MHP Supervision
12	Mental Health Service provided in Residential Settings	MHPs*	MHCP** under MHP Supervision
13	Peer Support	Only Certified Peer counselors who are also MHPs*	Certified Peer

* MHPs as defined within this document.

** Mental Health Care Provider means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

*** Peer Counselor means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Division of Behavioral Health and Recovery DBHR; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the (DBHR); and is registered as a counselor with the Department of Health.

	Benefit/Service Modality	Eligible to Bill Encounter	Eligible to Bill Fee for Service
14	Psychological Assessment	Licensed psychologists or MHPs* under supervision of Licensed psychologist	Licensed psychologists or MHPs* under supervision of Licensed psychologist
15	Rehabilitation Case Management	MHPs*	MHCP** under MHP Supervision
16	Special Population Evaluation	MHPs* who are Mental Health Specialists as defined in WAC 388-865-0150	MHPs* who are Mental Health Specialists as defined in WAC 388-865-0150
17	Stabilization Services	MHPs*	MHCP** under MHP Supervision
18	Outpatient Mental Health Rehabilitation Services – Therapeutic Psychoeducation	MHPs*	MHCP** under MHP Supervision

* MHPs as defined within this document.
 ** Mental Health Care Provider means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.
 *** Peer Counselor means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Division of Behavioral Health and Recovery DBHR; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the (DBHR); and is registered as a counselor with the Department of Health.

Rehabilitative Services (Tribal MH Services) Service Description Table

Service Title	Service Description
<p>Brief Intervention Treatment:</p>	<p>Solution focused and outcomes oriented cognitive and behavioral interventions intended to reduce symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from brief intervention treatment to longer term individual services at any time during the course of care.</p>
<p>Crisis Services</p>	<p>Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation.</p>

Service Title	Service Description
<p>Day Support</p>	<p>An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.</p>
<p>Family Treatment</p>	<p>Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan.</p>

Service Title	Service Description
<p>Freestanding Evaluation and Treatment</p>	<p>Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Division of Behavioral Health and Recovery (DBHR) to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.</p> <p>This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.</p>
<p>Group Treatment Services</p>	<p>Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the individual service plan. Goals of group treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for group treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.</p>

Service Title	Service Description
<p>High Intensity Treatment</p>	<p>Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual’s need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for high intensity treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.</p> <p>The team consists of the individual, and mental health care providers under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team’s intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.</p>
<p>Individual Treatment Services</p>	<p>A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual’s behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual’s self-care/life skills; monitoring the individual’s functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual.</p>

Service Title	Service Description
Intake Evaluation	An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, rehabilitation case management services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service must be provided by a mental health professional.
Medication Management	The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.
Medication Monitoring	Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

Service Title	Service Description
<p>Mental Health Services provided in Residential Settings</p>	<p>A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than high intensity treatment. The mental health care provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.</p>
<p>Peer Support:</p>	<p>Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.</p> <p>Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor’s own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.</p>

Service Title	Service Description
<p>Psychological Assessment</p>	<p>All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.</p>
<p>Rehabilitation Case Management</p>	<p>Psychiatric inpatient discharge planning and facilitation. A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual.</p>
<p>Special Population Evaluation</p>	<p>Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.</p>
<p>Stabilization Services</p>	<p>Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.</p>

Service Title	Service Description
<p>Therapeutic Psychoeducation</p>	<p>Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the individual service plan.</p> <p>The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one’s disease, the symptoms, precautions related to decompensation, understanding of the “triggers” of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.</p> <p>Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment and individual treatment are not billable components of this service.</p>

Tribal Billing Codes

Encounter Codes

	Billing Taxonomy	Native	Non-Native	Diagnosis Code
Medical Encounter	208D00000X	T1015-UA	T1015- SE	As appropriate
Psychiatric visit using Medical NPI*	2084P0800X	T1015-UA	T1015- SE	290-319
Dental Encounter	122300000X	T1015-UA	T1015- SE	520-5259 or V722
Mental Health Encounter	2083P0901X	T1015-HE	T1015- SE**	As appropriate
Chemical Dependency Encounter	261QR0405X	T1015-HF	T1015-HX If the tribe wishes to be reimbursed for this service a special account must be established with the state treasurer. Contact your RA for more information.	30390 (alcohol dependency) 30490 (drug dependency). For youth and pregnant & postpartum women, the following diagnosis codes may be used to distinguish abuse: 30500 (for alcohol abuse) 30590 (for drug abuse)
Medication Management	208D00000X	T1015-UA	T1015-SE	V58.83

*12 psychiatric visits per calendar year for clients 19 years of age and older and 20 visits per calendar year for clients 18 years of age and younger.

**Please refer to the Clinical Family definition in the Definitions section.

***Federal match must be provided by the billing tribe.

	Billing Taxonomy	Native	Non-Native	Diagnosis Code
Therapy Encounter	208D00000X	T1015-UA	T1015-SE	Occupational V5721 Physical V573 Speech V571

Fee-for-Service					
	Billing Taxonomy	Native	Non-Native	Procedure Code	Diagnosis Code
Medical Fee-for-Service (FFS)	As appropriate	CPT-UA	CPT-SE	As appropriate	As appropriate
Dental FFS (<i>Use ADA Form</i>)	As appropriate	CDT	CDT	As appropriate	Not applicable

Canadian First Nation Medicaid Eligibility

Certain individuals may be entitled to benefits such as Medicaid, Supplemental Security Income (SSI), Food Stamps, Disability, Social Security if they:

- Were born in Canada;
- Have at least 50% Aboriginal blood; and
- Are unable to work or lose their job.

Click on the following hyperlink to read more about *Border Crossing Rights Between the United States and Canada for Aboriginal People*:

<http://www.washingtonlawhelp.org/wa/showdocument.cfm/doctype/dynamicdoc/ichannelprofileid/43127/idynamicdocid/4516/iChannelID/7/foreignlanguage/1>.

Medicaid

What it is: It is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.

Eligibility: In some states people automatically qualify for Medicaid if they qualify for SSI benefits. Other states have their own eligibility rules.

Who to contact: [Social Security Administration](#) at 1-800-772-1213 or the local State Medicaid agency.

The right to this benefit is guaranteed by U.S. law 8 U.S.C. §1612(b)(3).

Crossing the U.S. Border to Live and/or Work

If an individual was born in Canada and has at least 50% Aboriginal blood, he or she has the right to enter the U.S. to live or work. This right is guaranteed by federal statute (8 U.S.C. §1359) and the federal court case *Akins v. Saxbe*, 380 F. Supp. 1210 (D.Me. 1974).

When individuals cross the border with intent to live or work in the U.S., they must be able to prove that they have at least 50% Aboriginal blood. U.S. Immigration and Naturalization Service (INS) ports of entry or border crossings may ask for different kinds of documentation depending on the port of entry or border crossing. At the border, individuals may be asked for **any** or **all** of the following documents:

- A letter from the band office stating that the individuals have at least 50% Aboriginal blood (also referred to as blood quantum);
- The individuals; Certificate of Indian Status Card (the card with the red stripe along the top);
- The individuals' long form birth certificate;
- The individuals' photo ID;
- If the individuals are Haudenosaunee, who have Red I.D. Card; or
- If the individuals are Inuit, their Inuit enrollment card from one of the regional Inuit lands claim agreements.

If the Social Security Administration is uncooperative about accepting the individuals' letter of quantum or any other piece of the above documentation to prove alien status, refer them to the following regulations from the Social Security Administration's own handbook:

- **SI 00502.105** - "Exemption from Alien Provisions for Certain Non-citizen Indians"
- **RM 00203.430** - "Evidence for an SSN Card for an Alien Lawfully in the U.S. Without INS Documents"

IHS Manual

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part2/pt2chapt3/pt2chpt3.htm#7>

An Indian is not required to be a citizen of the U.S. to be eligible for contract health services (CHS). The Indian (e.g., Canadian or Mexican) must reside in the U.S. and be a member of a tribe whose traditional land is divided by the Canadian border (i.e., St. Regis Mohawk, Blackfeet) or Mexican border (i.e. Tohono O'Odham).

Services Card

The plastic “Services Card” will replace the current paper Medical Assistance ID (MAID) card that is sometimes referred to as the medical coupon. The Services Card, like the MAID, is free to clients. Although the client card is changing, the rules the Department uses to determine client eligibility are not.

Some of the differences between the MAID and the permanent plastic “swipe” Services Card include:

- The Services Card will be issued one time, not on a monthly basis;
- The Services Card will only display the client’s name and ProviderOne Client ID number;
- The Services Card will not display eligibility type, coverage dates or managed care plans;
- The Services Card will not guarantee that a client with a card is eligible for medical services;
- The Services Card will be issued to each eligible member of a household;
- The Services Card will be issued centrally, not locally. Clients will receive their Services Card in about 7-10 days after approval for medical assistance.

Why is The Department making this change?

The plastic Services Card is more durable and cost-effective. If the card is lost or stolen, the client’s privacy is not compromised. Personal information like a client’s date of birth is not printed on the card. The Services Card resembles and is used much like other insurance industry cards. It has a magnetic strip that gives providers the option to acquire and use swipe card technology as one method to access the most up-to-date client eligibility information.

The front of the card will look similar to this:



The back of the card will look similar to this:



This card has a magnetic strip that gives providers the option to acquire and use swipe card technology as one method to access the most up-to-date client eligibility information.

How Do I Check a Client's Eligibility with the New Services Card?

There are several no or low cost options available to check a clients eligibility coverage.

- Web inquiry using ProviderOne
- New Interactive Voice Response (IVR) (Enhanced) 1-800-562-3022
- Medical Eligibility Verification (MEV) Vendor
- The Magnetic Card Readers
- Customer Service Center

Medical Identification Description Table

Medical Coverage Group Identifier	Medical Coverage Group	Public Assistance Type	Explanation of Medical Care Coverage	Specific Assistance Type for Treatment Expansion
C01, C95, C99	HCS (COPES) Waiver, DDD Waivers, or Hospice medical	Medical Assistance Only		SSI Related
D01, D02	Foster Care, Adoption Support, and JRA	Medical Assistance Only		Youth – Foster Care
F01, F02, F03, F04, F09, and F10	Family Related Medical including adults	TANF		TANF
F01, F02, F03, F04, F06, F09, F10	EMER and Related Services Only	None	Chemical dependency treatment MUST be billed using an A-19.	Alien Emergency Medical for TANF or Youth
F05, F06, F10, F99	Children’s Medical Program (some with premiums)	Medical Assistance Only		TANF Related Medical
F07	State Children’s Health Insurance Program (CHIP)	Medical Assistance Only		CHIP Child
F08	Children’s Health Program (CHP)	Medical Assistance Only		Undocumented Alien Child Medical

Medical Coverage Group Identifier	Medical Coverage Group	Public Assistance Type	Explanation of Medical Care Coverage	Specific Assistance Type for Treatment Expansion
G01	General Assistance - medical care services	General Assistance- Unemployable (GAU)	Chemical dependency treatment MUST be billed using an A-19. Treatment Expansion funds cover outpatient and residential treatment services	GA-U
G02	General Assistance - medical care services	General Assistance – Presumptive Disability (GAX)		GA-X
G03, G95, G99	Alternate Living, non-institutional medical	Medical Assistance Only		SSI Related
H01		Medical Assistance Only		Youth Medical
I01	Institution for the Mentally Diseased (IMD) medical	Medical Assistance Only		SSI Related
K01, K03, K95, K99	Family long term care medical	Medical Assistance Only		TANF or Youth Related Medical
K01, K03, K95, K99	EMER and Related Services Only	None	Chemical dependency treatment MUST be billed using an A-19.	Alien Emergency Medical for TANF or Youth
L01, L02, L04, L95, L99	Long-term care, nursing facility medical	Medical Assistance Only		SSI Related
L01, L02, L04, L95, L99	EMER and Related Services Only	None	Chemical dependency treatment MUST be billed using an A-19.	Alien Emergency Medical for SSI Related

Tribal Health Program

Medical Coverage Group Identifier	Medical Coverage Group	Public Assistance Type	Explanation of Medical Care Coverage	Specific Assistance Type for Treatment Expansion
P01, P02, P04, P99	Pregnancy related medical	Medical Assistance Only		TANF Related
P05	Family Planning Only medical	None	Chemical dependency treatment MUST be billed using an A-19.	None-Family Planning only
R01, R02, R03	Refugee Programs	Refugee Assistance		Refugee Program Medical
S01	SSI and SSI related medical (Aged,Blind, or disabled Adults)	Supplemental Security Income (SSI)		SSI
S02, S07, S08, S95, S99		Medical Assistance Only		SSI Related
S03	QMB-Medicare Only	None	Provides payment for only Medicare premium. Chemical dependency treatment MUST be billed using an A-19.	SSI Related
S04, S05, S06	Medicare Savings Programs	None	None Issued	SSI Related
S07, S95, S99	EMER and Related Services Only	None	Chemical dependency treatment MUST be billed using an A-19.	Alien Emergency Medical for SSI Related
W01, W02, W03	Alcohol and Drug Addiction Treatment and Support Act (ADATSA)	ADATSA	Chemical dependency treatment MUST be billed using an A-19. ADATSA funds cover outpatient and residential chemical dependency treatment services.	ADATSA

Notes:

- Treatment services for ADATSA clients (W01, W02, and W03) are paid through the county through specific contracts for services to this population.
- Treatment services for GAU clients (G01) are paid through the county contracts under the services to low-income clients. Clients may not be charged a fee towards the cost of treatment services.